MDDCSAM_FAV_SB334
Uploaded by: Adams, Joe
Position: FAV

SB 334: Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria Senate Finance Committee. February 19th 2020

SUPPORT

This law is needed to require carriers to report compliance with parity laws proactively, in a standardized manner, and with meaningful penalties for the non-compliance we have seen year after year, eleven years after the parity law was enacted.

Allowing carriers to remain out of compliance for so many years exacerbates the epidemic of overdose deaths, of increasing suicide rates, and of suffering from severe but treatable mental health disorders that affect whole families including children, much of which should have been prevented.

Penalties by the MIA have been embarrassingly low; they are clearly just a cost of doing business.

The grand total of all of the penalties for all carriers since the first 2014 compliance survey is a paltry $62,475. The only fines were **$25,000** for Cigna, another **$9,000** for Cigna, **$24,975** for CareFirst, and **$2,000** for United, and **$1,500** for Aetna.

The first survey revealed 6 parity violations. There were 6 administrative orders, **but only one fine against Cigna.**

Aetna had no in-network psychologists in all of 4 counties of Western Maryland, and no in-network psychotherapists in Garrett County. Coventry had no in-network methadone treatment centers in the state; Aetna had only two in the state. **There were no fines.**

CareFirst had no in-network methadone treatment programs across the State. A $30,000 penalty was retracted after CareFirst reached an agreement with the MIA.

For the second survey, some carriers reported that they did not have any in-network outpatient facilities for opioid use disorder and bipolar disorder in some counties, or any intensive outpatient programs for these conditions in some counties. Some cases carriers simply reported that there were no such providers willing to contract (under the terms that were offered). **There were no fines.**

For the third survey, many carriers were unable to produce written policies or reports of required annual review of internal policies and procedures for parity compliance. **There were no fines.**

The list goes on.

But California fined Kaiser $4 million, while New York sanctioned carriers a collective $2 million in fines for parity violations, and required $3 million in restitution to hundreds of consumers for out-of-pocket expenses, resulting in a 60% reduction in consumer complaints about access to mental health and addiction treatment services

Requirements for proactive reporting of parity compliance, by carriers, is long overdue.

****

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PGCEX_FAV_SB334

Uploaded by: Alsobrooks, Angela

Position: FAV

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

BILL:	**Senate Bill 334 – Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria**
SPONSOR:	**Senators Augustine and Hester**
HEARING DATE:	**February 19, 2020**
COMMITTEE:	**Finance**
CONTACT:	**Intergovernmental Affairs Office, 301-780-8411**
POSITION:	**SUPPORT**

The Office of the Prince George's County Executive **SUPPORTS Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria**, which requires carriers, on or before March 1 each year, to submit a report to the Maryland Insurance Commissioner to demonstrate the carrier's compliance with the federal Mental Health Parity and Addiction Equity Act. On or before March 1 each year, carriers must submit a report to the Commissioner on certain data for certain benefits by certain classification. The bill establishes the Parity Enforcement and Education Fund to provide funds to support and conduct outreach to inform consumers of their rights.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to prevent health insurers from providing less favorable mental health/substance use disorder coverage than for medical/surgical benefits.[1] However, enforcement of MHPAEA is almost non-existent – health insurance companies are only held responsible through lawsuits.

Insurance coverage disparities affect both patients and providers, and lead to poor behavioral health outcomes. In Maryland, patients are **ten times** more likely to pay for out-of-network coverage for behavioral health office visits than for primary care.[2]

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[1] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, H.R.6983, 110th Cong. § 2 (2008)

[2] Mental Health Association of Maryland (2019). *Milliman - New National Report Documents Increased Behavioral Health Disparities In Employer Sponsored Health Plans*. Lutherville, MD

47 STATE CIRCLE, SUITE 102 • ANNAPOLIS, MD 21401

Maryland behavioral health providers are also paid 18% less than primary care physicians for the same diagnostic codes.[3]

One in five adults in the United States experiences a mental illness[4], representing 140,000 Prince George's County residents.[5] Despite the high need, only 40% of adults with a mental illness received treatment in the previous year.[6] Increasing access to behavioral health services is more important now than ever before. SB 334 would help address unmet need by removing cost-related barriers to treatment. This will also improve quality of services by ensuring equal reimbursement for behavioral health providers.

MHPAEA was passed a dozen years ago – it is time to start holding insurers accountable. SB 334 strengthens Maryland's commitment to ensuring compliance and equal access to mental and physical health treatment for those in need.

For the reasons stated above, the Office of the Prince George's County Executive **SUPPORTS Senate Bill 334** and asks for a **FAVORABLE** report.

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[3] Mental Health Association of Maryland (2019). *Milliman - New National Report Documents Increased Behavioral Health Disparities In Employer Sponsored Health Plans*. Lutherville, MD
[4] National Alliance of Mental Illness (2019). *You Are Not Alone.*
[5] 2017 U.S. Census Population Estimates
[6] National Alliance of Mental Illness (2019). *You Are Not Alone.*

Bergan_FAV_SB334
Uploaded by: Bergan, Courtney
Position: FAV

Courtney Bergan
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cbergan@umaryland.edu

Senate Finance Committee Hearing, SB 334

February 19, 2020

Favorable

My name is Courtney Bergan. I am a graduate student in Social Work at the University of Maryland. I also have a professional background working in neuroscience research, and I have co-authored several publications related to neuropsychiatric disorders.

I support senate bill 334, implementing reporting standards for parity compliance and enforcement. I struggle with severe mental illness and obtaining appropriate care for my condition has required a disproportionate investment of time and effort when I compare it to my experiences seeking medical care. When seeking medical care, I don't have to think twice about basing my provider selection on network affiliation; I can simply choose the best specialist for my condition. I have repeatedly made significant sacrifices to obtain insurance coverage that is most likely to cover appropriate psychiatric care. Not only that, there are significant differences in how I see carriers reimbursing medical and psychiatric providers for the exact same services, with insurers allowing for greater reimbursement to medical providers. These disparate standards for the coverage of medical versus psychiatric care have had a significant impact on my health and my ability to participate in my life.

Due to the complexities involved in treating my psychiatric condition, there are few providers who are both able and willing to assume my care. There are even fewer who take insurance due to reimbursement rates that are not commensurate with the complexity of the care required for my condition. You may recognize me and my story, since I testified before this committee last year on a similar b after I spent more than 4 months contacting over 60 providers, desperately trying to locate an in-network provider who had the availability and expertise to assume my care. Accessing out-of-network psychiatric care is well beyond my means, as psychotherapy alone would have cost more than 50% of my income.

Due to my inability to access in-network mental health care, I began seeing a non-network specialist, who agreed to request a single case agreement with my carrier. The request for a single case agreement was initially denied within hours of my provider's request, with my carrier citing that I was not eligible for a single case agreement, despite the fact that my plan documents indicated I was. The day following my testimony before this committee, I finally received approval of the single case agreement that had been requested nearly two months earlier. Had I not received approval of that single case agreement, I am not sure I would be still be here and sitting before you again today.

While I was relieved to receive approval of the single case agreement with my psychologist, my relief was short lived. Last June I was notified that the University of Maryland Baltimore's student health insurance would be changing, leaving me without access to any of

my outpatient providers under my new carrier. As a result, I spent more than 4 months in the hospital, since I couldn't even find a psychiatrist who would prescribe my medications. This had significant personal costs to me, as I will now be delayed in completing my graduate degree by a year, but it also posed unnecessary costs to Maryland taxpayers. Maryland Medical Assistance is my secondary insurer, and they ended up paying for the portion of my inpatient stay that wasn't covered by my primary payor.

Furthermore, I have also struggled to obtain coverage of psychiatric medications, some of which are common, low cost generic medications. Due to my inability to obtain timely approval from my insurer for one of these medications, I ran out of my medication and I had a seizure as a result of the sudden withdrawal.

My experience demonstrates that discriminatory standards are still being applied to the coverage of behavioral health conditions when compared to those applied to the coverage of other medical conditions, despite state and federal Parity laws barring such discrimination. I should not be prohibited from participating in my education or community because insurers refuse to cover adequate care for my psychiatric conditions, nor should I have to invest more time or money in seeking mental health care than I do in seeking other medical care. Yet currently that is the case, because without parity compliance and enforcement, I am left with no other option. I support SB 334 so that health insurance carriers are required to demonstrate that they are not discriminating against individuals with behavioral health conditions, and they have an incentive to comply with existing Parity laws. The lives of too many Marylanders hang in the balance to continue ignoring this unlawful discrimination.

Encl: Correspondence with the MIA regarding Parity Compliance & Plan Approval Process

Courtney Bergan
6166 Parkway Drive, Apt 2
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Phone: (603) 770-5374

June 21, 2019

Maryland Insurance Administration
Attn: Consumer Complaint Investigation Life & Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000
Fax: 410-468-2270

Re: Request to deny approval of proposed 2019-2020 United Healthcare Student Resources Plan at University of Maryland Baltimore

To Whom it May Concern:

The University of Maryland Baltimore has proposed a change in its student health insurance plan to United Healthcare Student Resources, effective August 1st, 2019. The proposed plan is currently under review for approval by the Maryland Insurance Administration. I urge you to deny approval of this plan, pursuant to evidence that a contract between the University of Maryland Baltimore and United Healthcare would violate state contracting law, MD CODE, STATE FIN & PROC § 19-101, that provides as follows:

> "(a) It is the policy of the State not to enter into a contract with any business entity that has discriminated in the solicitation, selection, hiring, or commercial treatment of vendors, suppliers, subcontractors, or commercial customers on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, or on the basis of disability or any otherwise unlawful use of characteristics regarding the vendor's, supplier's, or commercial customer's employees or owners.
>
> (b) Nothing in this title shall be construed to prohibit or limit otherwise lawful efforts to remedy the effects of discrimination that have occurred or are occurring in the marketplace.
>
> (c) A complaint of discrimination shall be filed within 4 years after the date the cause of action accrues."

The recent *Wit vs. United Behavioral Health* decision handed down by Chief Magistrate Judge Joseph C. Spero of the U.S. District Court for the Northern District of California, on March 5, 2019, ruled that United Healthcare did not comply with generally accepted medical

criteria for approval of mental health and substance use disorder treatment. United Healthcare was found to be using unreasonable and overly restrictive guidelines which led to the inappropriate denial of coverage for thousands of patients. The findings in the *Wit vs. United Behavioral Health* Decision provide firm evidence that United Healthcare discriminated against thousands of its beneficiaries disabled by mental health and substance use disorders.

Furthermore, United Healthcare violates COMAR §31.10.44.05 related to network adequacy wait time standards. This is particularly apparent for behavioral health services, where United Healthcare only met the wait time standards 72% of the time. For urgent care, United Healthcare documented meeting the wait time standard only 63% of the time, however, this declines to 55% when urgent care facilities are removed from the data.

In concert, there is compelling evidence that United Healthcare has, and continues to, discriminate against those disabled by mental health and substance use disorders.

I, myself, have a disability, and I fear the repercussions this change in insurance carriers will have on my own, and other disabled students' access to healthcare. I will lose access to behavioral health services covered under the school's present insurer. Prior to having access to these specialized services, I spent almost 8 months in the hospital in 2018 alone. Interruption in that care would prevent me from being able to return to school in the fall and the United Behavioral Health network does not offer a provider with the appropriate training and experience to treat my condition. Furthermore, I was recently informed that United Healthcare is unlikely to cover the home care services I receive for my home infusion therapy. I require these services to be able to function in the classroom and in the world.

In addition, one of my fellow students is an amputee. Her prosthetic supplier who she moved here to access, is not covered under the proposed United Healthcare plan, potentially stealing her ability to walk independently. Other students have also reached out to me with concerns about losing access to their current behavioral health services, raising concerns about medication and provider access.

When concerns about provider access were raised with the University administration and Gallagher Student Health, students were informed that going out-of-network on the proposed United Healthcare Student Resources plan would be cheaper than accessing in-network services on our current CareFirst plan. While it is true that the out-of-network deductible and out-of-pocket maximum are lower on the proposed United Healthcare plan, as you are likely aware, out-of-network services are subject to balance billing. Due to insurers' undisclosed reimbursement rates, the out-of-pocket costs associated with such services remain unknown until they are billed. Not only that, any balance bill does not go towards *any* out-of-pocket maximum. Therefore, it is highly unlikely that receiving out-of-network care on the new student health plan, could be cheaper than receiving in-network care with CareFirst. Despite pointing this out to the UMB administration and Gallagher Student Health, this information has continued to be communicated to students.

If the United Healthcare Student Resources Plan is approved, it will have a disparate impact on students with disabilities. Please consider United Healthcare's multiple statutory violations and deny approval of this plan for students attending the University of Maryland Baltimore, so that all students, including those impacted by disability can continue to access necessary health care services. Access to healthcare is the linchpin in our ability to access our education.

Sincerely,

Courtney Bergan
Master in Social Work Candidate 2021
University of Maryland Baltimore
cbergan@umaryland.edu

Encl:
MD Code, State Finance and Procurement, § 19-101 obtained from Westlaw
AMA Issue Brief-Wit Decision
Network Adequacy Report for United Choice Network
Gallagher Student Health Summary of Changes to Student Health Insurance Plan
Email notification from UMB re change in student health insurance plan
Emails from Gallagher Student Health re student health insurance plan (2)
Email correspondence with UMB administration re concerns pertaining to information provided about student health insurance change

From: David Cooney -MDInsurance- <david.cooney@maryland.gov>
Sent: Tuesday, June 25, 2019 10:57:25 AM
To: Bergan, Courtney
Cc: Mehgan Sidhu; Savage, Katie
Subject: Re: Concerns r/t Pending Approval of United Healthcare Student Plan at U. Maryland Baltimore

Dear Ms. Bergan,

Thank you for your letter addressing your concerns with the University of Maryland Baltimore's proposed change to its student health insurance plan. I oversee the unit in the Maryland Insurance Administration (MIA) that reviews and approves the health insurance policies of insurance carriers before the carriers are permitted to sell their products in Maryland. I understand your concerns and sympathize with your situation, but unfortunately the MIA has no authority to address the particular concerns outlined in your letter, except as I otherwise explain below.

The MIA reviews and approves the policy forms and rates associated with student health plans that are intended to be sold in Maryland. However, the MIA has no jurisdiction over a specific group policyholder's decision to choose coverage with a particular insurance carrier. Under a group health insurance policy such as a student health plan, the policyholder (e.g. the university) has the right to select or change insurance carriers at any time without the consent of individual covered persons (e.g. students). In your situation, you may wish to discuss your concerns with the appropriate department of the University of Maryland Baltimore. Based on the supporting documents you included with your letter, it appears you have already attempted to do this.

Regarding the Unitedhealthcare Insurance Company student health plan in particular, please note that the policy forms for this product were filed with the MIA last year for the 2018-2019 school year, and were approved by the MIA on May 31, 2018. Unitedhealthcare did not make any changes to the approved forms for the 2019-2020 school year, so a new form filing was not required this year. Unitedhealthcare, did, however, revise the premium rates for the 2019-2020 school year, so a new rate filing was submitted to the MIA this year. The revised rates were recently approved on June 18, 2019.

I want to assure you that every health insurance product filed for approval with the MIA is reviewed for compliance with all applicable state and federal laws and regulations. This includes the federal Mental Health Parity and Addiction Equity Act and corresponding state mental health parity requirements. Accordingly, the Unitedhealthcare Insurance Company student health plan was subject to a rigorous review process before it was approved.

You are correct to note that the network adequacy standards in COMAR 31.10.44 are applicable to the Unitedhealthcare Insurance Company student health plan. However, state law does not require the provider network for a health benefit plan to be approved prior to selling the plan in Maryland. The next annual network access plan filing is due from carriers on July 1, and the MIA will be reviewing the plans very closely with a particular focus on access to mental health and substance use disorder services. Carriers will be expected to comply with all applicable standards or obtain an approved waiver of any standard that could not reasonably be met.

Finally, please note that the MIA is well aware of the Wit et al. v. United Behavioral Health U.S. District Court case, and will consider whether the court's findings should inform any future market conduct investigations or examinations. However, the court's decision is not by itself indicative of whether that UnitedHealthcare's student health plan in Maryland has violated any state or federal laws.

In conclusion, the Unitedhealthcare student health plan has already been approved by the MIA for sale in Maryland, but this approval was not granted until the MIA determined that the plan complied with all applicable laws and regulations.

Sincerely,

David Cooney, FLMI, AIRC
Chief, Health Insurance and Managed Care
Maryland Insurance Administration
410-468-2215
800-492-6116, Ext. 2215
410-468-2204 (fax)

Subject: Re: Concerns r/t Pending Approval of United Healthcare Student Plan at U. Maryland Baltimore
Date: June 27, 2019 at 4:21:58 PM EDT
To: David Cooney -MDInsurance- <david.cooney@maryland.gov>
Cc: darcim.smith@maryland.gov, nancy.grodin@maryland.gov, al.redmer@maryland.gov, Mehgan Sidhu <mehgansidhu@gmail.com>, "Savage, Katie" <ksavage@umaryland.edu>

Dear Mr. Cooney:

I appreciate you taking the time to consider my concerns related to the approval of the United Healthcare Student Resources plan for students at the University of Maryland, Baltimore.

I did just want to respond, as I testified on Senate Bill 631 in the 2019 legislative session that was intended to implement mandatory parity compliance reporting. The bill that was passed ultimately made the ASAM criteria mandatory for medical necessity determinations for substance use disorder services. However, due to persistent evidence of parity violations across carriers, I am continuing to work with interested parties to improve parity compliance and enforcement in Maryland.

As part of research I did this past semester at the University of Maryland and policy work I am involved in, I have become acutely aware that form review does not involve a complete review for Parity Act violations, since carriers are NOT required to provide information related to non-quantitative treatment limitations as part of the plan review and approval process in the state of Maryland. Therefore, the MIA cannot fully determine whether plans are compliant with the Mental Health Parity and Addiction Equity Act.

Despite the lack of information provided as part of the plan review process, I cited the *Wit et al vs. United Behavioral Health* decision, as it provides compelling evidence that United Healthcare, as an entity, has been using faulty medical necessity criteria to make coverage determinations for behavioral health services, and that such guidelines were not consistent with generally accepted medical necessity criteria for approval of such services. The ruling determines these overly restrictive guidelines were developed in an attempt to mitigate the financial impact of the 2008 Parity Act. This is clearly stated on page 93 of Judge Spero's ruling on the Wit decision. This is just one very clear example of a non-quantitative treatment limitation that is not included as part of plan review, but has a significant impact on plan beneficiaries.

Furthermore, United Healthcare plans administered in Maryland are part of the greater UnitedHealthcare Group, and therefore, such findings cannot be divorced from the carrier's practices in the state of Maryland. In fact, Maryland families have spoken out on the impact of United Behavioral Health's use of overly restrictive guidelines to determine coverage for behavioral health services. Maryland residents are amongst those impacted by United Behavioral Health's faulty coverage determinations, reporting restricted access to potentially life-saving healthcare services.

In addition, the MIA fails to assess other non-quantitative treatment limitations, such as equity in provider reimbursement, service restrictions, and treatment protocols. In conclusion, the plan review process fails to fully assess whether plans are indeed compliant with the 2008 Mental Health Parity and Addiction Equity Act.

Network Adequacy is one way policy makers have attempted to quantify a non-quantitative treatment limitation, by trying to ensure adequate access to provider networks for all services. While I understand inadequate provider networks are not, in and of themselves, a reason to deny plan approval. When there is a significant discrepancy in compliance with the network adequacy wait-time standards between physical and behavioral health services, this raises questions around parity compliance, based on disparate access to behavioral health services. The United Healthcare Choice network adequacy report indicates that there is a discrepancy in behavioral health access for more than 10% of United Healthcare beneficiaries in Maryland, raising red flags around the plan's compliance with the MHPAEA and warranting further investigation.

While I appreciate that you will take the *Wit et al vs. United Behavioral Health* decision into consideration, as to whether it should inform future market conduct surveys. This does not help to ensure the current plan being offered by United Healthcare Student Resources is compliant with the MHPAEA or determine whether United Healthcare is currently using discriminatory coverage guidelines. However, it does document discriminatory practices towards plan beneficiaries disabled by mental health and substance use disorders, therefore, again raising the issue that a contract between the University of Maryland, Baltimore and United Healthcare Student Resources would violate MD Code, State Finance and Procurement § 19-101, which is intended to prevent state entities from contracting with businesses that have records of discrimination.

I understand that the plan has already been approved, however, the plan has not yet gone into effect for students at the University of Maryland, Baltimore, so there is still time to prevent the violation of the state finance and procurement provision, that is specific to the plan's implementation at a state institution. I hope the MIA will consider this information and halt implementation of this plan.

Sincerely,

Courtney Bergan

Brown_FAV_SB334
Uploaded by: Brown, Stacey
Position: FAV

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SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Finance
February 19, 2020
Support

Last year, our 17 year-old son, who had been diagnosed with a substance use disorder as well as anxiety and depression, overdosed on a cocktail of Benadryl and Zzzquill. He was admitted to the Emergency Department where he remained in a hallucinogenic psychotic state for over 48 hours. Then he was sent to Sheppard Pratt, where he stayed for two weeks. The treating clinicians at Sheppard Pratt said that our son required a long-term residential treatment program to address his co-occurring mental health and substance use disorder. In fact, the social worker and psychiatrist said that he needed long-term inpatient treatment or was at risk for another overdose or death. While we were looking for such a program and had reached out to our insurance provider for help identifying a facility, we were abruptly told by Sheppard Pratt that our insurer only would cover his stay until that night – we had to come get him. We knew that he was not safe to come home, despite what our insurer said, but we had not yet found a residential treatment facility for him to transfer to. I spent 10 ½ hours on the phone the next day pleading with both our insurer and Sheppard Pratt to keep him longer; we were finally approved for three more days.

Although we had reached out to our insurer for help identifying an appropriate facility, they provided none. I searched through our insurer's website and found no in-network Maryland residential treatment centers for youth. I myself had to start searching on the insurer's web site state by state to try to find an appropriate provider for my son. No luck. Finally, through the SAMHSA web site, I found a residential treatment center in Pennsylvania that provided co-occurring mental health and substance use treatment for teens – Gateway.

Gateway had a 28 day program, and this is what the Sheppard Pratt clinicians had recommended that he receive at the very least. Our insurer, however, would only approve 3-5 days of residential treatment at a time. Then, after our son was there 12 days, our insurer denied continued coverage. Despite what the treating clinician at Gateway said, our insurer's clinician had determined that inpatient treatment was no longer medically necessary. Gateway told us that we would need to give them our credit card number or he would be released immediately. I fought with the insurance company for two hours and got nowhere. Finally, after I obtained the phone number (with tremendous difficulty) for our insurer's physician who had denied continued care and pled with him, our son was approved for five more days. Then our insurer approved three more days because of a snow storm. In the end our son was released after just 20 days of treatment, with no arrangements in place for him to transition to an intensive outpatient program.

We felt strongly that throughout this process our insurer was in violation of insurance parity requirements. They would not deny coverage for a somatic condition after a clinician said, for example,

that an individual required a number of chemotherapy treatments. They would not abruptly terminate treatment because **their** clinician determined that the individual no longer needed chemotherapy treatment, despite what the treating physician said. They would not re-determine medical necessity criteria every three days. They would have an adequate provider network.

Currently our son is living in active addiction. We have not had contact with him for months.

For these reasons I urge you to pass SB 334.

LowerShoreClinic_FAV_SB334

Uploaded by: Cavathas, Dimitrios

Position: FAV

Lower Shore Clinic
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Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am the CEO of Lower Shore Clinic, Inc, a community-based behavioral health provider located in Wicomico County. Our organization serves 1900 individuals every year, offering mental health evaluation and medication management, individual, group, and family counseling, medication assisted treatment, treatment planning, crisis planning, referral to specialty programs, and primary care services.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in my community.

Currently, there are limitations in our area for clients who have commercial insurers. In our area there is a wait period of at least 3 months to see a private psychiatric prescriber for members who have private insurance. Lower Shore Clinic has contracted with several commercial carriers, however there are still barriers for clients whose insurance transitions from public to private payors; creating gaps in care and often a relapse of illness.

Despite the great need for improved access to treatment, my organization has encountered barriers to increasing our participation in insurance plans offered by commercial carriers.

- Some insurances deny applications for therapists reporting that there is an adequate network of providers, despite waitlists. Many of these payors do accept applications for prescribers, which creates unrealistic expectations for the public who expect to see a prescriber without a therapist, something that is not best practice or supported by the OMHC model.
- Lack of coverage for many masters' level clinicians- such as LMSW, LGPC, RN-BC, RN-C, leading to a narrowing of available providers with whom a consumer can meet.
- The rates provided are not adequate to operate a free-standing clinic. We use other funding resources to float the Clinic operations and services.

When we aren't credentialed to serve an individual seeking care through an insurance plan, significant costs accrue to us as an organization or to the individual seeking care.

- Time spent on submitting redundant and duplicative applications

- Time spent researching denials and in vs out of network coverage
- Costs to the consumer whose insurance does not contract with provider types
- Variations in allowable amount creates strain and duplicative work for both billing submission configuration, adjustments, and application of payment.
- Reimbursement rates are significantly lower for many private insurers than from Medicaid/Medicare, sometimes by as much as 50%.

We believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

Dimitrios Cavathas, LCSW-C

CornerstoneMontgomery_FAV_SB334

Uploaded by: Cho, Cari

Position: FAV

Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am the President and CEO of Cornerstone Montgomery, a community-based behavioral health provider located in Montgomery County. Our organization serves 2,500 individuals every year, offering a full array of behavioral health services including Residential Rehabilitation, Vocational, Residential Crisis, Integrated Treatment for Co-Occurring Disorders, Outpatient Mental Health Clinics and Day Programs.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in my community.

Cornerstone Montgomery is an in-network provider with one commercial insurer and is seeking to be paneled with others. It is an administrative burden to become paneled with a commercial insurance provider as it requires us to credential each individual provider rather than being credentialed as a facility. This means we are credentialing a provider multiple times - once when we hire them as a Cornerstone Montgomery staff member and again for each commercial provider with whom we want to be paneled. These additional requirements result in a delay in initiating services as credentialing takes longer when you have to credential individuals as opposed to credentialing a facility. We were informed that once we submitted all of the requested paperwork it would be 60 days until we were paneled - in reality it took more than 8 months.

Many of our programs have a wait list and individuals seeking treatment often have to wait weeks or even months before being seen. For someone experiencing a mental health or substance use crisis, this can be a matter of life and death - for someone with commercial insurance this becomes even more urgent when they can't find an in-network provider.

Frequently, potential clients will seek services with us as an out-of-network provider. For these individuals, this often translates into higher out of pocket costs as the deductibles, and co-pays are often more than they would be for an in-network provider. This often means that the individual does not pay us and Cornerstone Montgomery is left providing un-reimbursed services. Commercial insurance only covers outpatient mental health services for in-network or out of network benefits. When someone calls seeking any of our other wrap around services, we have to tell them that they are in-eligible and the only way to become eligible would be to drop their private insurance and enroll in medicaid, shifting

the cost from commercial insurance to the state. Parity should ensure that medicaid is not the insurance of choice to be eligible for services that are critical to the recovery of people with mental health and substance use disorders.

We believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

Sincerely,

Cari Guthrie Cho, LCSW-C
President and CEO
Cornerstone Montgomery

BHRC_FAV_SB334
Uploaded by: Christensen, Tricia
Position: FAV

February 19, 2020

The Honorable Delores Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building, Annapolis, MD 21401

Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria - FAVORABLE

Dear Chair Kelley and Senate Finance Committee members,

Baltimore Harm Reduction Coalition (BHRC), an advocacy organization that mobilizes community members for the health, dignity, and safety of people targeted by the war on drugs and anti- sex worker policies, supports Senate Bill 334 which would require insurers to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act.

Historically, health insurance covered mental health care differently than other medical care. The federal Mental Health Parity and Addiction Equity Act was signed into law in 2008 with the goals of giving insured individuals easier and more affordable access to behavioral health care. However, **Maryland insurance companies have continued to dodge requests to demonstrate parity, and behavioral health care has not become more affordable or easier to access.**

A recent study conducted by Milliman, Inc. reflects worsened access to behavioral health care in Maryland since a similar study was published two years prior. Marylanders were 10 times more likely to go out-of-network for behavioral health visits compared to primary care. This rate is twice the national average and 4th worst in the nation. Additionally, reimbursement rates for Maryland psychiatrists was 18% less than other physicians for the same billing codes, demonstrating that insurance companies are not complying with Parity standards by reimbursing at different rates.

Access to behavioral health care is an important aspect of many people's pathways to healing and wellness, and insurance companies should be ensuring that people can access these services and that providers are fairly compensated.

BHRC respectfully requests the Committee give this measure a **favorable report**. Thank you for your consideration. For more information about BHRC or this position, please contact Tricia Christensen at Tricia@BaltimoreHarmReduction.org.

FFCP_FAV_SB334

Uploaded by: Christiansen, Todd

Position: FAV

7474 Greenway Center Drive, Suite 700B and 202, Greenbelt, MD 20770 Email: todd@ffcpmaryland.com
Telephone: 240-965-0076 (cell) 240-304-3327 (office) Fax: 410-609-7091

Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am the medical director and owner of Families First Counseling and Psychiatry, a community-based behavioral health provider located in several counties in Maryland (Montgomery, Prince George's County, Howard County, and Baltimore City). Our organization serves about 3000 individuals every year, offering in-home and community psychotherapy, family therapy, school based mental health services. and psychiatric treatment services. In addition, we provide dialectical behavioral therapy to clients who have Medicaid.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in the communities we serve.

We receive hundreds of referrals a month for services and we presently only accept Maryland Medicaid or people who are able to pay for services directly. In our group therapy program, we have children who are covered under Maryland Medicaid and parents who either are without insurance or have commercial insurance. Since the family component is vital for treatment, we provide the family therapy portion without charging our clients.

Commercial reimbursement rates rarely support the in-home and community-based work that our therapists provide to clients. In-home family therapy and community based 1:1 therapy is a powerful intervention for several conditions. Maryland Medicaid rates allow for these services as an outpatient mental health clinic. Commercial rates typically support an office-based approach only and rarely covers the off hours and emergencies that can occur. Commercial rates also do not cover the time for therapists to meet clients in home or in the community which helps to break down one of the barriers that exists for clients to receive mental health services.

Credentialing with commercial insurance is cumbersome and expensive and can take months or even over a year to complete. Behavioral health providers are frequently required to credential

each clinician individually instead of being credentialled as a group practice. We presently have over 90 therapists and every month are hiring between 2 to 4 new clinicians. The burden of individually credentialing each clinician, interns, and new hires poses an undue burden on our business. Because of these hurdles we have not yet started this process.

Despite the great need for improved access to treatment, my organization has encountered barriers to increasing our participation in insurance plans offered by commercial carriers.

Our largest concern is the low reimbursement rates and the difficulty in navigating the credentialing process.

When we aren't credentialed to serve an individual seeking care through an insurance plan, significant costs accrue to us as an organization or to the individual seeking care. This includes providing family therapy services and parent group services free of charge or at a steeply reduced self-pay rate, being forced to turn away possible referrals, or only being able to see some family members. In addition, we have had several patients who start off with Maryland Medicaid and then obtain commercial insurance. Since there is a lack of mental health providers, these patients either pay out of pocket or we continue to see them at a reduced rate to maintain continuity and be consistent with our policy of client centered care.

We believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

Sincerely,

2/18/2020

________________________ _____________

Todd Christiansen, M.D. Date
240-965-0076
License number: D0059971

NCADD_FAV_SB334
Uploaded by: Ciekot, Ann
Position: FAV

Senate Finance Committee
February 19, 2020

Senate Bill 334
Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria
Support

NCADD-Maryland supports Senate Bill 334. Our organization has accompanied people from the recovery community for years here in the General Assembly as they share story after story about difficulties accessing substance use disorder services through their commercial insurance. For many of you today, this issue is new from a policy perspective. Unfortunately, the stories have not ended, even 11 years after passage by Congress of the Mental Health Parity and Addiction Equity Act of 2008.

Insurance companies by law are only allowed to sell plans that are compliant with the Parity Act. If they are in compliance, it must be assumed they are already doing the analysis necessary to ensure compliance. It should not, therefore, be a burden to submit their analyses to the Maryland Insurance Administration (MIA).

Not only will consumers benefit from knowing the plans they are purchasing are compliant with the Parity Act, the MIA will benefit as they will not have to do retrospective market conduct surveys on this issue. The staff they have hired in recent years specifically for these surveys can now focus on prospectively reviewing plans. It is not only good public policy, it is logical to have plans demonstrate up front that they are in compliance.

Being in a state of emergency with regard to the opioid overdose crisis should mean that the private insurance market is doing its part.

We thank the sponsor of the bill for his work to bring the stakeholders together to work out a compromise. We are committed to agreeing to a final product that is meaningful and gets Maryland closer to full compliance with the Parity law.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

NAMI_FAV_SB334

Uploaded by: Cyphers, Moira

Position: FAV

NAMI National Alliance on Mental Illness | Maryland

February 18, 2020

Senate Bill 334 - Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria - SUPPORT

Chair Kelly, Vice Chair Feldman, and members of the Senate Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland is dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community.

One of our top advocacy priorities is eliminating barriers to effective treatment for individuals with mental illness. Unfortunately, we know that these roadblocks – whether it's cost, wait times, lack of insurance coverage, no in-patient beds, a dearth of treatment options for children and others - are myriad and especially problematic for individuals with mental illness and their families.

NAMI strongly supports the reduction of legal and other barriers that prevent access to timely, effective, and affordable services, including enhanced enforcement of insurance parity requirements. From routine denials of coverage to lack of in-network providers to burdensome authorization processes, accessing mental health care in Maryland is often difficult and expensive. And, it shouldn't be. There are federal protections in place that ideally, would protect Maryland consumers.

SB 334 would help address all of these concerns by helping us identify where the gaps are. By requiring a report from health insurance carriers and other health plans in Maryland detailing federal Parity Act compliance, we can start to piece together what services and coverage exist and where we can do better. The goal of the bill is to help advocacy groups like NAMI and state insurance regulators identify gaps in federally-required coverage, including reports about:

- In-network benefits and out-of-network benefits, substance use disorder coverage, prescriptions drug coverage, and other information.
- Specific information about all covered and not covered mental health benefits and treatment limitations.
- The numbers of plan members receiving mental health and substance use disorder services and more.

Despite state and federal laws which require parity, enforcement is virtually nonexistent. NAMI supports efforts like SB 334 to reduce barriers and increase access to effective treatment, reaching and treating individuals with mental illness, and inclusion of family members in all of these efforts. We will continue to advocate for effective outreach, engagement, treatment and community supports for all those affected by mental illness in Maryland, no matter their race, social, geographical, economic or other status. For these reasons, NAMI Maryland asks for a favorable report on SB 334.

Contact:
Moira Cyphers
Compass Government Relations
MCyphers@compass-gr.com (301) 318-4220

CCYSB_FAV_SB334
Uploaded by: Davis, Lynn
Position: FAV

CARROLL COUNTY YOUTH SERVICE BUREAU, INC.
59 KATE WAGNER ROAD – WESTMINSTER, MD 21157
410.848.2500 – 1.888.588.8441 – FAX 410.876.3016

Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am the executive director of the Carroll County Youth Service Bureau (CCYSB), a community-based behavioral health provider located in Carroll County. Our organization serves over 3,000 clients annually, providing over 16,000 sessions of therapy and psychiatric visits. CCYSB offers a wide range of programs and services, which include: individual outpatient treatment to children, adults, and families; four evidence-based treatments, group treatment in mental health and substance use, and Assertive Community Treatment, to name a few. We fulfill contracts with Carroll County Public Schools, the Department of Juvenile Services, Carroll County Department of Social Services, and the Local Management Board.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in Carroll County. Our agency consistently has a waitlist for clients who have private insurance. Our service provision for commercially-insured clients steadily remains in the range of 30%, in comparison to the much greater percentage of 70%, served through Medicaid and Medicare. The long process of credentialing therapists (hence fewer therapists paneled) is one of the main reasons why we have a much lower percentage of commercially-insured clients.

While Medicaid falls short of providing a rate that is commensurate with inflation, it is critical to note that the reimbursement rate of commercial insurance is even lower than that of Medicaid!

The barriers of the lengthy process of credentialing (or denying) therapists and the low rate of reimbursement, significantly affect our ability to increase our participation in insurance plans offered by commercial carriers. When we aren't credentialed to serve an individual seeking care through an insurance plan, the client is not able to use the insurance plan for which they are paying, and we serve the client at a much-reduced fee.

In summary, we believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – to ensure that Marylanders with behavioral health needs have improved access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

LATE - MoCoDeptHealthandHumanServices_FAV_SB334
Uploaded by: Dept of Health and Human Services, MoCo
Position: FAV

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Marc Elrich
County Executive

Raymond L. Crowel, Psy.D.
Director

February 19, 2020

SB334

Senator Malcolm Augustine
Senator Katie Fry-Hester
425 House Office Building
6 Bladen Street
Annapolis, MD 21401

Dear Senator Malcolm Augustine and Senator Katie Fry-Hester

The Mental Health Advisory Committee of Montgomery County (MHAC), as mandated by the State of Maryland, is dedicated to monitoring the delivery of mental health services to county residents. The Committee also collaborates with community partners to advise and advocate for an effective comprehensive mental health system of care for all. Achieving mental health parity is one of our main priorities. Enforcement is essential to achieving change.
As such we are writing to express our support for The Parity Transparency and Compliance bill (SB 334/ HB 455) which would improve access to life-saving mental health (MH) and substance use disorder (SUD) treatment by requires insurance carriers to:

- Submit an annual parity compliance report, modeled on the U.S. Department of Labor's Parity Act Self-Compliance Tool, and data related to benefit decisions.
- Pay penalties for parity violations and for filing incomplete reports.
- Make their compliance report available to plan members so they can enforce their parity rights.
- Inform consumers of their parity rights in benefit denial letters.

The bill would require the Maryland Insurance Administration (MIA) to review carrier reports, impose remedial measures to correct violations and reimburse consumers, and use penalties to improve parity enforcement and consumer information. The MHAC is especially interested in ensuring that citizens are able to access mental health and substance abuse services without discrimination, as is the law. Our committee is routinely addressing the concerns of Marylanders who are not able to access services that were prescribed by their treatment teams despite having health insurance. Others have only been able to receive services for themselves or their family members because of their continued diligence in advocating for services that should have immediately been authorized by their insurance carrier.

Behavioral Health and Crisis Services • Child and Adolescent Behavioral Health Services
7300 Calhoun Place, Suite 600 • Rockville, Maryland 20855 • 240-777-1432 • 240-777-4447 FAX
www.montgomerycountymd.gov/hhs

Although the Federal Mental Health Parity and Addictions Equity Act was passed in 2008 and Maryland has passed several laws to ensure parity in the management and treatment of mental and physical health conditions, we are concerned that health plans in Maryland are still not complying with these laws and the MIA is not adequately addressing these issues.
Despite the MIA identifying numerous parity violations through three market conduct surveys, carriers continue to implement illegal barriers to MH/SUD treatment. The MIA, however, has only issued nine (9) enforcement orders involving most Maryland carriers, and it has not imposed significant penalties for carrier violations.
The MIA currently cannot enforce the Parity Act in a timely and effective way unless carriers disclose their practices and are accountable for any standard that unfairly limits MH/SUD service and medication access. As an example, the MIA took 15-25 months to complete the first and second market conduct surveys, and the third is not yet complete after 26 months.

MIA's third survey report identified parity violations and other disparities that may result from discriminatory practices that prevent Marylanders from accessing the MH/SUD benefits they pay for.

- One carrier discriminatorily excluded 5 of 13 SUD treatment programs from its network but included all 122 medical facilities.
- One carrier denied inpatient MH/SUD services more frequently than inpatient medical services.
- One carrier imposed prior authorization requirements on all MH/SUD services but not all medical services.
- Carriers reported taking longer to credential MH/SUD facilities than medical facilities.
- All carriers reported that their members accessed MH/SUD services through out-of-network services more frequently than medical services.

Requiring carriers to submit parity compliance reports is the only way to ensure that health plans offer and deliver equal MH/SUD services. Since carriers are already barred under federal law from selling plans that do not comply with the Parity Act, carriers should already be conducting the analyses that SB 334/HB 455 would require.

We believe that this legislation will be effective because we have seen it work in seven other states who have adopted comparable carrier compliance reporting requirements to enforce MH/SUD parity.
Since 2018, six states – Colorado, Connecticut, Delaware, the District of Columbia, Illinois and New Jersey – have enacted laws requiring parity compliance reporting. In addition, California has required parity compliance reporting for all plan features since 2015. Massachusetts, Connecticut, and Vermont gather carrier data annually to identify disparities in MH/SUD benefit coverage, and New York implemented biennial data reporting standards in 2019.

The MHAC is mindful that there are limited state funds and resources available to address the mental health and substance abuse needs of our citizens. We want to ensure that those who currently pay for health insurance are able to use their insurance to access the services they need. When insurance companies prevent members from using their insurance to access these

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www.montgomerycountymd.gov

treatments, citizens often become increasingly ill and end up in our jails, emergency rooms, and shelters.

We believe that SB334/HB455 could help address these ongoing issues.

Sincerely,

Jeannette C. Bjorklund, LCSW-C

MHAC Co-Chair

Garrett Ford Mannchen

MHAC Co-Chair

CC: Chair Senate Finance Committee Delores G. Kelly
Vice-Chair Senate Finance Committee Brian J. Feldman

CBH_FAV_SB334
Uploaded by: Doyle, Lori
Position: FAV

Testimony on HB 455
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
House Health and Government Operations Committee
February 20, 2020
POSITION: SUPPORT

The Community Behavioral Health Association of Maryland is the professional organization for providers of community-based mental health and substance use disorder treatment services. Our members serve the majority of the almost-300,000 children and adults who access care through the public behavioral health system. We provide outpatient treatment, residential and day programs, case management and assertive community treatment (ACT), employment supports, and crisis intervention.

Despite passage of the federal parity law (the Mental Health Parity and Addiction Equity Act) IN 2008, there is overwhelming evidence of disparate treatment of behavioral health by insurance carriers, and unfortunately Maryland stands out as one of the worst offenders. Two reports by Milliman, Inc., one released in December of 2017 (analyzing claims during calendar years 2013 through 2015) and one in November of 2019 (analyzing claims for calendar years 2016 and 2017), found that reliance on out-of-network providers for outpatient mental health and substance use disorder treatment was significantly higher than that for primary care, and has not improved from the time of the initial report's release to the most recent report. Maryland's disparity in use of out-of-network office visits for behavioral health versus primary care was the 4th worst in the nation in 2017, and nearly twice the national average, and the 2017 reimbursement in Maryland for psychiatrists was 18% less than other physicians for the same billing codes, relative to the Medicare allowed amount.

The Maryland Insurance Administration (MIA) has historically relied on consumer and provider complaints to justify market conduct exams or other inquiries into carrier practices. Unfortunately, those seeking behavioral health treatment are often overwhelmed by a disorder that can make it very difficult to initiate complaints. In addition, stigma may discourage those with behavioral health disorders from speaking out about their challenges in seeking treatment. The Milliman evidence strongly suggests that carriers are not compliant with the federal parity law. We believe that the MIA must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for HB 455.

18 Egges Lane, Catonsville MD 21228 410.788.1865 mdcbh.org

LCPCM_FAV_SB 334
Uploaded by: Faulkner, Rachael
Position: FAV

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 334**
Title: **Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria**
Hearing Date: **February 19, 2020**
Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria.* This bill would require insurance carriers to report annually to the Maryland Insurance Administration on their compliance with the federal Mental Health Parity and Addiction Equity Act and authorize the Maryland Insurance Commissioner to impose penalties for noncompliance.

LCPCM strongly supports ensuring that Marylanders have access to behavioral health services, particularly as both the suicide rate and overdose deaths among Marylanders remain high. Federal law requires that coverage of behavioral health services be on par with coverage for somatic care. Unfortunately, as behavioral health providers, we continue to regularly encounter limitations in coverage, particularly with regard to the reimbursement of services.

Through required annual reporting to the Maryland Insurance Administration, this bill will help ensure that coverage of behavioral health services is fair and equitable in the insurance market.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Rachael faulkner at rfaulkner@policypartners.net or 410-693-4000.

MNA_FAV_SB 334
Uploaded by: Faulkner, Rachael
Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 334**

Title: **Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria**

Hearing Date: **February 19, 2020**

Position: **Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria.* This bill would require insurance carriers to report annually on their compliance with the federal Mental Health Parity and Addiction Equity Act and establishing the Parity Enforcement and Education Fund.

MNA has been a strong supporter of efforts to increase access to behavioral health services across the state. This includes our support for HB 1318 (Ch. 309) in 2016, which required the Maryland Insurance Administration to promulgate regulatory standards regarding network adequacy by geographic accessibility, average wait times for appointments, and provider to enrollee ratios for both primary and specialty care.

In addition to the criteria included in the network adequacy requirements, this bill will ensure that coverage for behavioral health services is on par with somatic health services and that insurance carriers are not limiting access by establishing more restrictive policies behavioral health services. Without a mechanism to review and enforce federal parity requirements, many patients in Maryland with a behavioral health condition will continue to wait for needed behavioral health treatment or unnecessarily pay out-of-pocket for treatment, when they're able to, even when they have insurance coverage.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

MOTA_FAV_SB 334
Uploaded by: Faulkner, Rachael
Position: FAV

Maryland Occupational Therapy Association

PO Box 131 ♦ Stevenson, Maryland 21153 ♦ mota.memberlodge.org

Committee: Senate Finance Committee
Bill Number: Senate Bill 334
Title: Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Hearing Date: February 19, 2020
Position: Support

The Maryland Occupational Therapy Association (MOTA) supports *Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria.* This bill would require insurance carriers to report each year to the Maryland Insurance Administration on their compliance with the federal Mental Health Parity and Addictions Equity Act.

Occupational therapists address barriers that individuals with mental health conditions experience in the community by providing interventions that focus on enhancing existing skills; remediating or restoring skills; modifying or adapting the environment or activity; and preventing relapse. As such, both the National Board for Certification in Occupational Therapy (NBCOT) and the American Occupational Therapy Association (AOTA) include mental health services within the scope of practice for occupational therapists. [1]

Unfortunately, carriers do not all consistently recognize occupational therapy practitioners as mental health providers and it remains difficult for outpatient mental health programs to employ occupational therapists due to inconsistent reimbursement. We support this bill as it creates a mechanism to regularly collect data on which services are provided, and perhaps more importantly, which services are being denied. This should assist both the MIA and MOTA in ensuring that occupational therapy is a covered benefit for individuals in mental health treatment.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[1] National Board for Certification in Occupational Therapy – Certificate Renewal.
https://www.nbcot.org/Certificants/Certification

American Occupational Therapy Association – Occupational Therapy's Role in Community Mental Health.
https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/MH/Facts/Community-mental-health.pdf

MCF_FAV_SB334
Uploaded by: Geddes, Ann
Position: FAV

SB 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria

Senate Finance Committee
February 19, 2020
POSITION: Favorable

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers and other loved ones, our staff provide one-to-one support and navigation services to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

MCF held focus groups with families who were caring for a youth or young adult with a substance use disorder. The majority of these families had a young adult with an opioid use disorder. When asked what were the greatest obstacles they encountered when trying to access help for their child, by far the most frequent response was limited insurance coverage, and being overwhelmed by out of pocket costs. We heard numerous instances of insurance parity violations:

- Although a licensed provider, having performed an assessment, determined that an individual needed residential treatment, the insurer would initially only pay for outpatient treatment, requiring that the individual "fail first' at the outpatient treatment before the insurer would authorize residential treatment.
- While an individual was in residential treatment, the insurer required a medical necessity determination every few days in order to authorize more days of treatment. Even when the treatment provider's physician reported that the individual needed more days of residential treatment, the insurer refused to cover additional days because their reviewer determined that the individual was ready to be discharged.
- While an individual was in residential treatment, the insurer required a medical necessity determination every three days in order to authorize more days of treatment. Some residential providers will not accept an individual for residential treatment unless they know that they will be able to work with them for a set period of time, so this insurance practice of only approving a few days of treatment at a time prevents people from being accepted into many treatment facilities.

Given that Maryland remains in the midst of an opioid overdose epidemic, these insurance practices are putting people's lives at risk.

Caregivers of children with mental health disorders too experience parity violations. While some (but not all), insurers will cover up to 30 days in a Maryland Residential

Treatment Center, again they will only authorize 3-5 days at a time. If the child is still in an RTC after 30 days, they become eligible for Maryland Medicaid as a family of one, and the state, not the insurer, picks up the remaining tab. Families experience relief at this point - children usually stay in Maryland RTCs for six to nine months.

In all of these cases, families did not know that they were experiencing a violation of insurance parity. Families are not experts in insurance law, and especially when they are in the middle of a crisis, they are not in a position to do research on the fine points of insurance parity requirements. Putting the onus on families to identify and prove a parity violation is simply not fair – the onus should be on the insurance companies to show that they are in compliance with the laws. SB 334 would put this requirement in place.

Therefore we urge a favorable report on SB 334.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
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MdCSWC_Pam Kasemeyer_FAV_SB0334
Uploaded by: Kasemeyer, Pam
Position: FAV

The Maryland Clinical Social Work Coalition

The MdCSWC, sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland.

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Steven S. Hershey, Jr.

FROM: Judith Gallant, LCSW-C, Chair, Maryland Clinical Social Work Coalition

DATE: February 19, 2020

RE: **SUPPORT** – Senate Bill 334 – *Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria*

The Maryland Clinical Social Work Coalition (MdCSWC), sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland. On behalf of MdCSWC, we **support** Senate Bill 334.

There continues to be significant concerns in the behavioral health provider community regarding commercial insurers compliance with federal and state parity laws that require that the coverage for mental health and substance use disorder services is at the same level as other medical benefits. Consumers continue to experience challenges accessing care from network providers and receiving the authorization for required covered services.

Passage of Senate Bill 334 provides a number of tools to ensure greater accountability by insurance carriers with respect to parity compliance. The legislation requires carriers to submit two reports: 1) an annual report to the Maryland Insurance Administration (MIA) to demonstrate compliance with the federal Parity Act; and 2) carrier's data for mental health benefits, substance use disorder benefits, and medical/surgical benefits. The bill allows the MIA to impose a penalty for non-compliance, which would go into a newly created Parity Enforcement and Education Fund to provide monies to support the MIA's enforcement efforts. Finally, the bill adds a clause to the appeals and grievance laws regarding the ability to file a complaint with the MIA or Health Advocacy Unit if an individual believes that he/she has been aggrieved by a carrier's non-compliance.

Despite the steps taken to ensure parity with other medical benefits, access to mental health and substance use disorder benefits continues to be a challenge. Senate Bill 334 will provide the MIA with the necessary data to ensure that carriers are compliant and will require carriers that are found not to be compliant to make the necessary changes. A favorable report is requested.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
Richard A. Tabuteau
410-244-7000

Greater Washington Society for Clinical Social Work: www.gwscsw.org
Contacts: Coalition Chair: Judy Gallant, LCSW-C; email: jg708@columbia.edu; mobile (301) 717-1004
Legislative Consultant: Pamela Metz Kasemeyer, Schwartz, Metz & Wise PA, 20 West Street, Annapolis, MD 21401
Email: pmetz@smwpa.com; mobile (410) 746-9003

Danna Kauffman_FAV_SB0334
Uploaded by: Kauffman, Danna
Position: FAV

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS
Serving Maryland and Delaware

The Maryland State Medical Society
1211 Cathedral Street
Baltimore, MD 21201-5516
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TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Malcolm Augustine

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
Richard A. Tabuteau

DATE: February 19, 2020

RE: **SUPPORT** – Senate Bill 334 – *Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Mid-Atlantic Association of Community Health Centers, we submit this letter of **support** for Senate Bill 334. Beginning in 2021, Senate Bill 334 requires insurance carriers to submit two compliance reports to the Maryland Insurance Administration (MIA) on: 1) the carrier's compliance with the Parity Act; and 2) the carrier's data regarding the delivery of mental health benefits, substance use disorder benefits and medical/surgical benefits. The bill specifies what must be included in each report and allows the MIA to impose a penalty for non-compliance, which would go into a newly created Parity Enforcement and Education Fund to provide monies to support the MIA's enforcement efforts. Lastly, the bill adds a clause to the appeals and grievance laws regarding the ability to file a complaint with the MIA or Health Advocacy Unit if an individual believes that he/she has been aggrieved by a carrier's non-compliance.

Senate Bill 334 is a consumer protection bill to ensure that carriers are complying with required parity laws and are only selling plans that do comply. Access to mental health and substance use disorder benefits continues to be a challenge despite the steps taken to ensure parity with other medical benefits. Senate Bill 334 will provide the necessary data to MIA to ensure that carriers are compliant and will require carriers that are found not to be compliant to make the necessary changes.

We urge a favorable vote.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
Richard A. Tabuteau
410-244-7000

MHAMD_FAV_SB334

Uploaded by: Martin, Dan

Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 334 Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Finance Committee
February 19, 2020
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to present this testimony in support of Senate Bill 334.

Under federal and state parity laws, Marylanders are entitled to receive mental health and substance use disorder benefits at the same level as other medical benefits. Unfortunately, many commercially insured Marylanders still face barriers in accessing behavioral health services that are not imposed for medical and surgical benefits.

SB 334 requires greater accountability by insurance carriers so that regulators and consumers know whether private health plans comply with parity protections. The bill requires carriers to:

- Submit an annual parity compliance report, modeled on the U.S. Department of Labor's Parity Act Self-Compliance Tool, and data related to benefit decisions;
- Pay penalties for parity violations and for filing incomplete reports;
- Make their report available to plan members; and
- Inform consumers of their parity rights in benefit denial letters.

The Maryland Insurance Administration (MIA) would be required to review carrier reports, impose remedial measures to correct violations and reimburse consumers, and use penalties to improve parity enforcement.

Although MIA has identified numerous parity violations through market conduct surveys, carriers continue to implement illegal barriers to behavioral health treatment. Requiring carriers to submit parity compliance reports is the only way to ensure that health plans offer and deliver equal access to mental health and substance use treatment.

This bill will give regulators the information they need to ensure health plans comply with the law, require insurance carriers to fix violations promptly, and ensure consumers receive the behavioral health care they've paid for. **For these reasons, MHAMD supports Senate Bill 334 and urges a favorable report.**

For more information, please contact Dan Martin at (410) 978-8865

SheppardPratt_FAV_SB334
Uploaded by: McCleaf, Kylie
Position: FAV

Sheppard Pratt
HEALTH SYSTEM

Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am Kylie McCleaf, chief of children and family services for Sheppard Pratt Health System, the largest nonprofit provider of mental health, substance use, special education, developmental disability, and social services in the country. As a nationwide resource, we serve more than 70,000 people annually across 160 programs in 16 Maryland counties, spanning both hospital- and community-based services.

Our outpatient mental health services include school and home-based mental health services, outpatient mental health services for adults and children, and a coordinated specialty care team for individuals with new on-set psychosis.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in our communities.

- The large outpatient Mental Health Center (OMHC) and the school and home-based services programs are only able to accept private insurance when an existing client transitions from public insurance to private insurance, in order to promote continuity of care during client's life transition, due to the capacity of our medical providers and the credentialing of our staff. Psychiatry time is a commodity that is increasingly expensive and represents high cost to the OMHC and the rates of reimbursement by many insurance companies cannot cover the cost of prescribing time and the program cannot sustain additional financial loss. Currently, we are referring privately insured clients to other community providers and often hear the stories of individuals struggling to find credentialed providers to obtain the mental health care they need. We do not keep a waitlist as our belief is that people cannot wait for care and need to link to appropriate services immediately.

Despite the great need for improved access to treatment, our organization has encountered barriers to increasing our participation in insurance plans offered by commercial carriers.

- One of the largest barriers to accepting private insurance has been the credentialing process that may take 8 weeks to complete. Recently LM level social workers have been able to be credentialed with private insurances and this has

assisted in creating a much-needed workforce. However, it is difficult to maintain credentialed providers in an OMHC as private practice is more attractive to many fully licensed providers. The timeframe to credential a new provider is prohibitive as a new staff member cannot build a caseload until they are credentialed, and most individuals cannot wait months to start a new job and begin receiving reimbursements.

- The rates of many private insurances are also prohibitive as the rate is often lower than Medicaid rates and do not provide adequate margins to cover the expenses of the OMHC, this is especially true of child and adolescent psychiatry services.
- Other barriers include the somewhat complex or differential rules around billing and combination of service rules.

When we aren't credentialed to serve an individual seeking care through an insurance plan, significant costs accrue to us as an organization or to the individual seeking care.

- The difficulty in credentialing or lapses in credentialing often yield services that cannot be reimbursed. This cost is evidenced by uncollected/bad debt by the agency. Clients often struggle to pay their deductible or co-insurance and the agency has ethical obligations to treat clients based on their acuity or need and this further reduces the agency reimbursement for services, despite attempts to collect.

We believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

CenterforChildren_FAV_SB334
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Testimony on SB 334
Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
Senate Finance Committee
February 19, 2020
POSITION: SUPPORT

I am the Executive Director of Center for Children, Inc., a community-based behavioral health provider located in 5 counties but whose main office is in Charles County. Our organization serves approximately 4100 children and families every year, offering Outpatient, Psychiatric Rehabilitation, Wraparound Care Coordination, Substance Use, and many other trauma and child serving programs.

Improving access to mental health or addiction treatment for individuals with commercial insurance is a critical need in my community. We are routinely turned down to add additional new clinicians to our provider group from several insurance companies citing a full panel. However I have at any given time waitlists for 3-4 months for children with private insurance.

Despite the great need for improved access to treatment, my organization has encountered barriers to increasing our participation in insurance plans offered by commercial carriers.

- Long gaps from original application date until notification (if we even get notified), even though they often retroactively date them to application date, which in fact, obscures the length of processing. We do not feel we can take the risk and nonpayment until the person is credentialed.
- We get denials on application for 3 of the carriers due to panels being full, and they include 30 mile radius which for us takes our families across the Woodrow Wilson Bridge.
- Our rates for therapy are about 60% of what we get paid by federal payers, yet they require the highest level of licensure

When we aren't credentialed to serve an individual seeking care through an insurance plan, significant costs accrue to us as an organization or to the individual seeking care, as well to the taxpayers of Maryland as research shows that Adverse Childhood Experiences have long lasting and expensive consequences.

- Families choose not to get care due to wait times
- Children are sometimes "out of school" until they can show they are in services
- Managing a wait list is time consuming for office staff and begs a liability to all of us

We believe that the Maryland Insurance Administration (MIA) must be proactive in examining carrier practices – including carriers' actual implementation of policies that impact access to behavioral health treatment – in order to ensure that Marylanders with behavioral health needs have access to services for which they pay their insurance premiums.

We urge a favorable report for SB 334.

A United Way Organization

HEAU_FAV_SB0334
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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
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February 19, 2020

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: Patricia F. O'Connor, Health Education and Advocacy Unit

Re: Senate Bill 334 (Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 334 because the bill could improve the delivery of mental health and substance use disorder treatments in Maryland. Currently carriers are not adequately reporting to the Maryland Insurance Administration (MIA) about whether or not their plans, as written and in operation, have parity between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits, as required by the Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act). Without operational information, the MIA cannot meaningfully assess or enforce carriers' compliance with the Parity Act. This bill would impose detailed reporting requirements of operational parity information, among other information, on carriers in Maryland.

By focusing on parity in the operation of health plans, we may achieve progress in addressing the persistent problems facing insureds who require MH/SUD treatments: inadequate networks, unaffordable prescription drugs, and criteria that limit the scope or duration of benefits for services provided under a plan. These nonquantitative treatment limitations (NQTLs) may not be more stringent for MH/SUD benefits than for medical/surgical benefits, and there must be parity in operation as well as on paper. Examples of NQTLs include:

• Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);

• Formulary design for prescription drugs;

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• Network tier design;

• Standards for provider admission to participate in a network, including reimbursement rates;

• Plan methods for determining usual, customary, and reasonable charges;

• Fail-first policies or step therapy protocols;

• Exclusions based on failure to complete a course of treatment; and

• Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

Only comparisons of decision-making processes and outcomes within each category can establish whether carriers are more stringent regarding MH/SUD benefits than medical/surgical benefits. For example: Are reimbursement rates for providers of the two classes of benefits in parity or not? Are standards for provider admission to the plan's network in parity or not? Is there parity between the facilities required for SUD treatment (e.g., methadone clinics) and medical treatment (e.g., dialysis clinics)?

The Parity Act requires carriers to assess and document plan parity as written and in operation, but not a single carrier could produce documentation of an operational plan review as required by the Act when the MIA conducted its 3rd market survey. The bill's enhanced reporting requirements are necessary so that consumers may have verification that Maryland carriers are complying with the Parity Act.

Seven states have adopted comparable carrier compliance reporting requirements to enforce mental health parity (California, Colorado, Connecticut, Delaware, District of Columbia, Illinois, and New Jersey). In addition, Massachusetts, Connecticut and Vermont gather carrier data annually to identify disparities in mental health coverage, and New York implemented biennial data reporting standards in 2019. We believe improved parity is necessary for consumers of MH/SUD treatments, and that this bill would improve parity.

For these reasons, we ask for a favorable report by the Committee.

cc: Members of the Finance Committee

MHA_FAV_SB334
Uploaded by: Raswant, Maansi
Position: FAV

Maryland
Hospital Association

February 19, 2020

To: The Honorable Delores G. Kelley, Chairman
Senate Finance Committee

From: Maansi Raswant, Vice President, Policy
Maryland Hospital Association

Re: Letter of Support - Senate Bill 334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria

Dear Chairman Kelley:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 334. Maryland's nonprofit hospitals and health systems care for millions of people each year, including many seeking care for mental health and substance use-related disorders. However, efforts to place these patients at appropriate levels of care, particularly post-discharge, are hindered by seemingly arbitrary coverage decisions due to lack of transparency in insurers' benefits design and coverage policies.

SB 334 requires insurers to include detailed information on utilization management requirements and coverage decisions, such as prior authorization and concurrent/continuing review processes for needed services. This information about health care coverage is instrumental for hospitals and providers to better collaborate with insurers to support patients through the care continuum and place them in the most optimal, high-value care settings. However, currently this data is not provided on a systematic, transparent basis.

For the past two years, the Maryland Insurance Administration (MIA) found insurers do not meet regulatory parity standards for mental health and substance use disorder treatments—specifically for nonquantitative treatment limits, including network adequacy.[1] Yet, the reports carriers are required to file with MIA showing challenges meeting parity standards remain unavailable for review by providers and the public. This opaque process prevents critical stakeholders from providing valuable input to MIA and carriers on meaningful solutions to address issues with true impact to health care coverage and delivery.

Under Maryland's Total Cost of Care Model, providers and insurers must effectively work together to meet the Model's goals to provide high-value care to all Marylanders. As part of this Model and beyond, hospitals are measured on several facets of health care delivery at the state and federal levels, including utilization, quality, and cost. But success under these measures, and under the Model, does not solely depend on factors within hospitals' control. Access to high-

[1] See Maryland Insurance Administration Mental Health Parity and Addiction Equity Act Compliance Surveys. *Available at*: https://insurance.maryland.gov/Consumer/Pages/MHPAEA-Enforcement-Actions.aspx

value care is also significantly impacted by insurance coverage. The reporting requirements under SB 334 are a start for hospitals, providers, and all health care stakeholders to better understand this impact.

For more information, please contact:
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Spiegel_FAV_SB334
Uploaded by: Spiegel, Jessica
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February 19, 2020
Senate Finance Committee Hearing
SB 334 – Health Insurance – Coverage for Mental Health and Substance Use Disorder Benefits – Treatment Criteria
SUPPORT

As a provider of behavioral health services, I am writing in support of SB 334, a bill that will protect consumers and place the burden on insurers as parity for mental health treatment is still in the dark ages. My experience as a provider of services has shown me how difficult it is to participate in insurance networks. I started the credentialing process in September of 2019 and am still awaiting a final contract with CareFirst. Unfortunately, CareFirst is the only carrier with which I am getting credentialed because it is the only insurer that offers decent reimbursement rates. Cigna, United, and Aetna's rates are currently below the Medicaid rates in the state of Maryland. I have been a licensed social worker for 10 years, have specialty training in EMDR, and cannot afford to cut my rates to comply with these insurers while giving my patients the time and effort they need and deserve. These rates do not represent parity for mental health treatment. I have several patients that would benefit from weekly therapy but are unable to afford to come in as often as they would like due to cost. My hope is that when I am credentialed with CareFirst, this burden will be lifted off of some of my patients, however I am also aware that there will likely be delays in payment and other difficulties with reimbursement. Ask any provider of services about their experience with insurance companies and you will hear horror stories. The state of Maryland Medicaid right now is another dark tale, which is extremely concerning when more and more consumers are enrolling in Medicaid because they cannot access the scope of mental health services they need under their former private insurance. The state decided to "save" 70 million dollars by going with Optum as their new gatekeeper for behavioral health services. The process has been a mess, some providers have not received any reimbursement in 2020, and the ones that have are receiving it based on their weekly averages from 2019. Providers are now unable to accept new Medicaid patients, and Outpatient Mental Health Centers are facing difficulties paying their staff, depriving Marylanders of the care they need. This is a step backwards, and the state of Maryland should not have these problems. We want to reduce the need for psychiatric hospitalizations, yet we do not have adequate provider networks. Networks are inadequate not because there aren't enough mental health providers, but because the insurance companies have gotten away with discriminating against behavioral health consumers for decades. It is unacceptable that if you need mental health treatment you could spend hours trying to find an in-network provider, only to find out they are not accepting new patients or are no longer actually in network. People who are fortunate to have the means to pay out-of-pocket often give up trying to go through their insurance because it is so burdensome, and those who cannot afford to pay go untreated. We are seeing the outcome of this with increase suicide rates, mass shootings, overdoses, etc. It is time to acknowledge the prevalence of mental health disorders among all Americans and hold insurance companies accountable to the Parity Act. All Marylanders deserve quality mental health treatment that they can afford, and providers deserve to be fairly compensated

for their training and expertise. SB 334 would ensure transparency and accountability of insurers to comply with the Parity Act and protect patients and providers from this ongoing discrimination. I urge you to report favorably on SB 334. Thank you.

MPS_FAV_SB334
Uploaded by: Tompsett, Tommy
Position: FAV

February 19, 2020

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: Support – SB 334: Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) is a state medical organization whose physician members specialize in the diagnosis, treatment, and prevention of mental illnesses including substance use disorders. Formed more than sixty years ago to support the needs of psychiatrists and their patients, MPS works to ensure available, accessible and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branch of the American Psychiatric Association covering the state of Maryland excluding the D.C. suburbs, MPS represents over 700 psychiatrists as well as physicians currently in psychiatric training.

MPS supports Senate Bill 334 (SB 334), which would require the Maryland Insurance Commissioner to ensure that carriers in the state demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Patients with mental illness, substance use disorders, or the comorbidity of both mental illness and substance use disorder often face additional barriers to receiving adequate care than patients who seek treatment for somatic illnesses. SB 334 would address a part of that inequity by requiring carriers to submit a report on how they design and apply non-quantitative treatment limitations for mental health and/or substance use disorders treatment. Additionally, SB 334 authorizes the Insurance Commissioner to levy fines for MHPAEA non-compliance.

Ensuring access to quality evidence-based services to treat mental health and/or substance use disorders should be a priority for legislators, particularly at a time when our state is experiencing an ongoing suicide epidemic and opioid crisis. Even a small delay in coverage for these services can pose irreversible harm to individual patients and produce higher downstream costs to the health care and social service systems, such as inpatient hospitalizations, patient death or disability, and avoidable emergency room utilization and boarding.

As an organization that represents the front-line physicians treating patients with mental illness and/or substance use disorders, MPS urges the committee to provide a favorable report on SB 334. If you have any questions with regards to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Legislative Action Committee for the Maryland Psychiatric Society

Pathways_FAV_SB334
Uploaded by: Watkins, Daniel
Position: FAV

Anne Arundel Medical Center

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To: Senate Finance Committee
From: Pathways, an affiliate of Anne Arundel Medical Center
Re: SB334 – Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria
February 18, 2020
SUPPORT

Pathways, an affiliate of the Anne Arundel Medical Center that provides a range of treatment services for people with substance use disorders, supports SB 334, which would require private insurers to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (Parity Act).

The Parity Act bars insurers from implementing plan standards, known as non-quantitative treatment limitations, more stringently for substance use disorder (SUD) and mental health (MH) benefits than for medical and surgical benefits. In our experience, some carriers do not comply with the Parity Act's non-discrimination standard when making medical necessity determinations for SUD treatment. In particular, most insurers usually refuse to authorize Residential Rehabilitation treatment for patients who have completed detoxification (ASAM Level 3.7-WM) and will instead authorize a lower level of care not medically appropriate for the patient's condition. This practice is inconsistent with the ASAM level of care standards which are the required medical necessity criteria for SUD treatment in Maryland. This more stringent application of medical necessity criteria, through its focus on acute signs of withdrawal, leaves gaps in the appropriateness and adequacy of care.

The 3.7 Residential Rehabilitation level of care is a critical step-down service in the continuum of care following treatment for acute withdrawal from substances, and provides a period of medical stabilization and adequate preparation to support discharge to a home environment. Transfers from Level 3.7-WM to Level 3.7 are often prescribed after the symptoms of withdrawal are addressed, as many patients continue to need monitoring for co-occurring mental health or other conditions that were masked by substance abuse and emerge following detoxification. Residential Rehabilitation services include physician monitoring, nursing care, and observation; additional specialty consultation, psychiatric services, laboratory and toxicology services are available on-site. These services are not provided or reimbursed on an outpatient level of care such as a Partial Hospitalization Program (PHP).

For some of our patients after initially completing detoxification treatment, their payors will only approve a PHP level of care, meaning fewer hours of care and limited medical monitoring. These payors refer patients to Pathways, because we embed this service level within our inpatient program to ensure adequate monitoring of the newly detoxified patient's condition. However, for the consumer, this means the payor—their insurance—only reimburses for some of the services they receive; and remaining costs shift to the individual. Pathways' other patients are also impacted; when patients

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cannot afford to pay the costs shifted by their insurer, the result is limited funds for Pathways to expand offerings, scope, and treatment.

Other payors deny Level 3.7 and authorize an even lower level of care following acute detoxification – an Intensive Outpatient Service (IOP) - rather than the prescribed Residential Rehabilitation. Transfer from 3.7-WM detoxification to the significantly less extensive outpatient IOP level of care, places our patients at serious risk of relapse as these insurers will not cover the appropriate step-down treatment. With improper treatment, complex medical and psychiatric needs following detoxification will not be addressed unless the patient seeks additional concurrent treatment from additional providers.

When insurers inappropriately implement medical necessity criteria for patients with substance use disorders, they violate the Parity Act. This proposed bill would ensure that payors report on the treatment limitations that they use and are held accountable if they apply those requirements more stringently to mental health and substance use disorder benefits.

Strong enforcement of the Parity Act is important for patients and programs, like Pathways, but it is also critical to the financial health of Maryland. There has been a marked decline in the number of patients with commercial coverage enrolling in our services. Anecdotally, we know that some families remove their young adult children from their private insurance plans in order to become eligible for Medicaid. In Maryland, Medicaid covers the full scope of SUD services and clinically appropriate lengths of stay necessary to improve patient health. If Maryland's commercial insurers are not doing the same, they are directly putting patients at risk, violating the Parity Act, and unnecessarily shifting costs to consumers, providers, and the state.

For these reasons, Pathways supports SB334 and encourages the committee to give a favorable report so that individuals can access the clinically appropriate services that are covered under their health plans and should be reimbursed by insurers.

Thank you for your consideration.

Daniel Watkins MSN, RN, NEA-BC
Director of Substance Use Services
dwatkins@aahs.org

Legal Action Center_Support_SB 334
Uploaded by: Weber, Ellen
Position: FAV

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Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria – SB 334
Senate Finance Hearing
February 19, 2020
SUPPORT

Thank you for the opportunity to submit testimony **in support of SB 334** which would: (1) establish annual carrier compliance and data reporting standards to improve state enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (Parity Act); and (2) inform consumers of their rights under the Parity Act when denied a service for mental health or substance use disorder treatment.

This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination against individuals with histories of substance use disorders, HIV/AIDs and criminal history records and promotes sound public policies to expand access to health services for these individuals. The Legal Action Center also leads the Parity at 10 Campaign in Maryland to improve enforcement of the Parity Act: **an 11-year old federal statute** that prohibits discriminatory coverage of and access to mental health (MH) and substance use disorder (SUD) benefits in state-regulated individual, small group and large group plans. The Parity Act provisions have been incorporated into Maryland's mandated MH and SUD benefit. *See* Ins. § 15-802.

Maryland's regulators, working with provider and consumer stakeholders, have taken important steps to enforce the Parity Act in private and public insurance. **But those efforts clearly point to the need for a carrier compliance reporting model to improve the state's enforcement strategies. Compliance reporting is needed to root out well-documented discriminatory practices so that consumers get the services they need, pay for, and are entitled to receive under state and federal law.**

I. Documented Discrimination in Insurance Coverage of Mental Health and Substance Used Disorder Benefits

The Maryland Insurance Administration (MIA), at the request of the Senate Finance Committee in 2015 and in connection with a previous compliance reporting bill (SB 586/HB 1010), has conducted three market conduct surveys to assess carrier compliance with the Parity Act. Although the third survey is not yet complete, the MIA has identified parity violations by virtually all the state's carriers in the area of network adequacy: the one plan feature that the MIA investigated in-depth for discriminatory plan practices. The MIA has issued a total of 9 finals orders and, in its second and third reports, identified practices that suggest violations of the Parity Act, even if not addressed in an order. The MIA's orders, investigative findings and penalties penalties are summarized and provided in Attachment 1.

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The MIA's third report contains troublesome findings regarding the carriers' failure to (1) conduct the most basic compliance reviews required by the Parity Act and (2) document the reviews they claim to conduct. According to the MIA:

- Carriers that have delegated responsibility to another entity to administer MH and SUD benefits did not include Parity Act compliance requirements in their contracts.
- Carriers did not document their policies and process for conducting "as written" compliance reviews and failed to provide any documentation of their "as written" reviews.
- Carriers failed to conduct "in operation" compliance reviews and some had no teams to conduct audits.

A second source of Maryland carrier data – the July 2018 and 2019 network adequacy reports – also suggests underlying Parity Act violations. For the second network adequacy reporting period, only 1 of 6 carrier networks reported compliance with the State's appointment wait time metric of providing non-urgent MH and SUD care within 10 days for 95% of plan enrollees. COMAR § 31.10.44.05. *See* Attachment 2. Carrier compliance rates for MH and SUD services were far worse than compliance for somatic services. This gap in network provider panels points to underlying network admission practices, reimbursement rate standards and utilization management practices that likely constitute a Parity Act violation.

Maryland's consumers and providers cannot wait any longer for carrier accountability, which can only be achieved with the submission of a compliance and data report.

II. Legal Framework for Compliance Reporting and the MIA's Enforcement Process

The federal Parity Act regulations explicitly bar insurers from selling plans that do not comply with the Act's requirements (45 C.F.R. § 146.136(h); 29 C.F.R. § 2590.712(h)). **This means that carriers should already be conducting the parity compliance analysis that would be required under SB 334. The MIA's third market conduct findings unfortunately confirm that carriers are not conducting the required analyses.**

If carriers had any doubt about the scope of the analysis required under the Parity Act, the U.S. Departments of Labor (DOL) and Health and Human Services created a clear roadmap in its April 2018 *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act.* (Available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.). The DOL Self-Compliance Tool sets out an 11-step process that requires reporting and analysis of all financial requirements, quantitative treatment limitations, non-quantitative treatment limitations (NQTLs) and plan disclosure requirements. The NQTLs, which are the focus of the proposed compliance and data report in SB 334, are limitations on care access that are not expressed numerically, such as prior authorization and continuing authorization requirements, medical necessity criteria, network adequacy, reimbursement rates and prescription drug coverage.

The Self-Compliance tool is also crystal clear that health plans must be prepared to provide all the information on the above plan features, including "records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical as well as MH/SUD benefits to ensure they can demonstrate compliance with the law." Self-Compliance Tool at 20.

The MIA reviews several, **but not most**, of the required elements in the Self-Compliance Tool in its plan approval process. It annually examines plan compliance with financial requirements for individual and small group plans under the Parity Act, benefit coverage and exclusions, and ensures that lifetime and annual dollar limits are not imposed on plans in violation of the Affordable Care Act. Maryland Insurance Administration Bulletin 18-03 (Jan. 26, 2018) at 3. (Available at https://insurance.maryland.gov/Insurer/Documents/bulletins/18-03-2019-Affordable-Care-Act-Rate-and-Form-Filing.pdf.) **The MIA does not, however, investigate NQTLs** since those features are not evident on the face of plan documents. Apart from the required market conduct surveys, the MIA relies on consumer complaints or market conduct exams to identify standards that unfairly deny access to MH and SUD services. **To examine those critical plan features systematically, the MIA must request that information from carriers who have sole possession of that information and, as noted above, should have already gathered and analyzed for compliance.**

SB 334 tracks the DOL's compliance analysis and would also require carriers to submit quantitative data on 5 metrics that are needed to document the implementation of plan practices under the NQTL requirement. Under the Parity Act, the "rules" for establishing an NQTL must be comparable to and applied no more stringently for MH/SUD benefits that for medical/surgical benefits both "as written" in the policy and as implemented "in operation." (45 C.F.R. § 146.136(c)(4); 29 C.F.R. § 2590.712(c)(4)). The date metrics are essential to examine the implementation of the plan and uncover disparate practices that may reflect an underlying Parity Act violation.

The identification of disparate metrics was central to the New York Attorney General's enforcement actions against New York carriers that resulted **in 8 settlements with 7 different health plans, requiring them to change their practices, return $2 million to patients and pay $3 million in penalties.** New York State Office of the Attorney General, Health Care Bureau, Mental Health Parity: Enforcement by the New York State Office of the Attorney General (May 2018), https://ag.ny.gov/sites/default/files/hcb_mental_health_parity_report.pdf. The proposed metrics track some of the information the MIA requested in its third market conduct survey and data that the DOL has identified as key to a compliance review. Self-Compliance Tool at 17.

III. Limitations of a Complaint Process to Uncover Parity Violations

The MIA relies heavily on complaints to uncover Parity Act violations and has encouraged MH and SUD providers to file complaints when carriers inappropriately deny services. **A complaint process, however, is ill-suited to uncover Parity violations.**

We know from the Attorney General's Annual Report on the Health Insurance Carrier Appeals and Grievances Process that a relatively small percentage of consumers file a grievance of a carrier's adverse MH or SUD decision. In 2019, carriers reported issuing 790 adverse decisions for MH/SUD services (1.05%) with 108 (1.26%) internal grievances filed; far fewer than the rate of internal grievances of adverse decisions for physician services (7.39%). Office of the Attorney General, Annual Report on the Health Insurance Carrier Appeals and Grievances Process: FY 2019 at 22, available at

http://www.marylandattorneygeneral.gov/CPD%20Documents/HEAU/Anual%20Reports/HEAUannrpt19.pdf. **This does not mean, however, that parity violations do not exist.**

The Parity at 10 Campaign conducted a survey in mid-2018 in five states, including Maryland, to evaluate whether consumers were aware of the Parity Act protections, including their right to challenge an adverse decision that denied or limited care. The survey results (based on a convenience sample and not randomized) suggest that consumers are not aware of their right to appeal an adverse decision, are more likely to file an appeal for a medical condition than a MH/SUD decision, and are more inclined to accept a carrier's decision for a MH or SUD denial than to appeal it. Among the survey respondents of 1,239 individuals, 545 (44%) of whom were Marylanders, 62% had employer-based insurance. The key findings are:

- Only half (49%) of consumers knew that a denial of a MH/SUD service can be appealed and 13% were not sure.
- 60% of consumers who had been denied care accepted their health plan's denial of care, and 33% reported filing an appeal with their insurance company.
- Nearly all consumers (93%) reported that they would "be likely" to challenge a denial of coverage for a medical service, but only 78% of consumers reported they would "be likely" to file a denial of coverage for a MH/SUD service.

Available on www.parityat10.org. Beyond a consumer's lack of knowledge about appeal rights and tendency to accept rather than appeal a carrier's denial, other factors contribute to the limited number of parity complaints.

- Neither the consumer nor the provider possesses the plan information that is required to determine whether a parity violation exists.
- Many practices that violate the Parity Act relate to plan practices that patients have no influence over, such as network adequacy and reimbursement rate setting, and cannot be appealed through a grievance process.
- In the midst of a crisis, family members are fighting to get the care needed to save the life of a loved one and most have no capacity to pursue a complaint.
- Most parity violations are systemic in nature and will not be rooted out through an individual complaint, even if one were filed.

SB 334 would improve a consumer's awareness of their rights under the Parity Act by including notification of those rights in adverse decision letters. **That alone will not root out parity violations: compliance reporting is needed.**

IV. Parity Enforcement in Other States: Compliance and Metric Reporting

In light of the limitations of plan review and consumer complaints, an increasing number of state regulators and legislatures have adopted compliance reporting requirements and many others are considering bills that would do so. SB 334's parity compliance reporting requirements are consistent with enforcement requirements that have been adopted in legislation by 5 other states, Colorado, Connecticut, Delaware, Illinois, New Jersey, and the District of Columbia. Each state's reporting provisions are set out in Attachment 3. Delaware and the

District of Columbia have begun collecting compliance reports, as of July 2019 and October 2019, respectively, and the other states will begin collecting reports in 2020 and 2021.

Two states have imposed compliance reporting through regulatory agency actions. Since October 2013, Massachusetts has required carriers to submit an annual certification of Parity Compliance to the Division of Insurance and plan information regarding the implementation of medical necessity criteria and authorization processes to demonstrate compliance. Div. of Insurance Bulletin 2013-06 (May 31, 2013); M.G.L. ch. 26, § 8K. California's Dept. of Managed Health Care has required issuers to provide detailed pre-market parity compliance information for financial requirements, and quantitative and non-quantitative treatment limitations since late 2014. CAL. HEALTH & SAFETY § 1374.76.

Five states, including Colorado, Connecticut, Massachusetts, New York, and Vermont, and the District of Columbia also require carriers to submit compliance data consistent with the proposed data requirements in SB 334. *See* Attachment 4 for required State metrics. Delaware's Department of Insurance has also required carriers to submit audits of parity compliance that include data elements proposed in SB 334. *See* Attachment 4.

Maryland has been a leader is expanding access to mental health and substance use disorder services and protecting the Affordable Care Act standards that ensure insurance coverage for Marylanders who suffer from a mental health or substance use condition. But we can and must do more to stem the tide of our opioid and suicide crises and ensure the delivery of appropriate treatment services. **Insurance carriers must show that they are living up to non-discrimination standards that have been in place for over a decade and cover the services that consumers are paying for and are entitled to receive.**

We urge a favorable report on SB 334.

Ellen M. Weber, JD
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ATTACHMENT 1

MIA Orders and Market Conduct Survey Findings: Parity Act Compliance

Carrier	Order/ Date	Violations	Penalty
Aetna/Coventry[i]	MIA-2015-12-035	• No in-network psychologists in all of Western Maryland • 2 counties with no in-network psychiatrists and 1 county had 1 • 1 county no in-network licensed professional counselors or licensed social workers • Statewide - 1 or no in-network methadone treatment programs	No Financial Penalty
CareFirst Blue Choice	MIA-2015-10-036	• Statewide - no in-network methadone treatment programs • Different reimbursement rates for MH/SUD network because used a separate vendor to manage MH/SUD benefits • Geofactors applied to somatic illnesses not applied to MH/SUD providers	Initial Financial Penalty of $30,000; Retracted Based on Consent Order
CareFirst GHMSI	MIA-2015-10-034	• Failure to meet network adequacy goals for neuropsychological doctors and geriatric psychiatrists	No Financial Penalty
Cigna[ii]	MIA-2015-10-007	• Additional screening requirement for MH/SUD credentialing • Requirement that MH/SUD applicants who had received treatment for SUD must be sober for 2 years • Imposed shorter response time for MH/SUD providers to submit requested credentialing information	$9,000 Financial Penalty

Evergreen	MIA- 2015-10-033	• Used 2 different vendors for MH/SUD services and somatic services and no coordination to ensure no more stringent credentialing requirements • Used different factors to set reimbursement rates for MH/SUD • 1 county - no in-network psychiatrists, psychologists, licensed social workers or professional counselors	No Financial Penalty
United Healthcare[iii]	MIA-2017-08-009	• Reviewed 5-year malpractice history for all MH/SUD facilities applying for credentialing but no malpractice review for med/surg facilities	$2,000 Financial Penalty
CareFirst BlueChoice, Inc. GHMSI (CareFirst BlueCrossBlueShield)	MIA-2018-01-023	• BlueChoice – on-line behavioral health directory failed to list 25 of 27 in-network MH hospitals and 5 of 7 MH non-hospital facilities • BC/BS Blue Preferred – online behavioral health directory failed to list any in-network inpatient MH facilities	$20,250 Financial Penalty against BlueChoice $4,725 Financial Penalty Against CareFirst BC/BS
Second Market Conduct Survey Other Findings	June 2017 MIA indicated carriers corrected issues during investigations. Carriers not identified	• Carrier limited disclosure of med/surg medical necessity criteria to 3 guidelines at a time to member/provider • Large group plan – financial testing did not account for all OP benefits • Carrier – on-line directory indicated no in-network inpatient MH facilities • Carrier's credentialing documents for MH/SUD	

		providers required site visit but not for med/surg providers • Carrier reported different authorization practices in notices for inpatient MH/SUD treatment and med/surg treatment.	
Second Market Conduct Survey Other Findings	June 2017 Carriers with inadequate networks not identified	• 6 counties – no in-network non-hospital facilities for opioid use disorders[iv] • 11 counties – no in-network non-hospital facilities for treatment of bi-polar disorders[v] • 4 counties – no in-network opioid providers[vi] • 7 counties – no in-network providers of bi-polar disorders[vii]	No Financial Penalties or Other Actions Taken
Aetna	MIA-2018-10-037	• Required MH/SUD outpatient and inpatient facilities to complete detailed Personnel Review for credentialing; medical facilities not required to complete Personnel Review	$1,500 Financial Penalty
Cigna	MIA-2019-06-012	• Denied credentialing for 5 of 13 SUD treatment facilities based on "no network need identified." Admitted all 122 medical facilities even though "no network need identified."	$25,000 Financial Penalty
Third Market Conduct Survey Other Findings	Sept. 18, 2019 MIA indicated that carriers corrected issues during investigations but investigation was not complete.	• 1 carrier imposed prior authorization requirements on all MH/SUD services but not all medical services • 1 carrier's standards for submitting malpractice history during credentialing differs for	No Financial Penalties or Other Actions Taken

	Carriers not identified	MH/SUD facilities and med/surg facilities • 1 carrier imposed 7-day cap on the number of days for inpatient MH/SUD authorization, but no cap on inpatient medical services	
Third Market Conduct Survey Other Findings	Sept. 18, 2019 Carriers not identified.	• All carriers reported that non-network MH/SUD services are accessed more frequently than non-network med/surg services • Some carriers took longer to credential MH/SUD facilities than med/surg facilities • Carriers have not assessed "in operation" compliance; some carriers have no team to conduct compliance audits • Some carriers have no policies for conducting review of plan compliance and some have no documentation of reviews • Contracts with entities that manage MH/SUD benefits do not address Parity requirements.	

[i] Includes Aetna Health Inc., Aetna Life Insurance Co., Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Co.

[ii] Includes Cigna Health and Life, Insurance Co. and Connecticut General Life Insurance Company.

[iii] Includes MAMSI Life and Health Insurance Company, Optimum Choice, Inc,. UnitedHealthcare Insurance Company, All Savers Insurance Company and UnitedHealthcare of the Mid-Atlantic, Inc.

[iv] Calvert, Charles, St. Mary's, Allegany, Garrett and Washington Counties had no in-network opioid treatment facilities.

[v] Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot Counties had no in-network non-hospital facilities for bi-polar disorder treatment.

[vi] Garrett, Queen Anne's and Worchester Counties had no in-network opioid treatment providers.

[vii] Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester Counties had no in-network providers for bipolar-disorders.

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June 29, 2016

The Honorable Thomas McLain Middleton
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015 - Final Summary of Survey One Analysis

Dear Senator Middleton:

In light of testimony and discussion of Senate Bill 586 (2015), the Maryland Insurance Administration ('MIA") was requested to (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with MHPAEA and applicable State mental health and addiction parity laws and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division sent a survey to carriers issuing fully-insured group and individual qualified health benefit plans on the Maryland Health Benefit Exchange (*See* Attachment A). All carriers responded, and subsequent investigations were opened. As all the pending hearings and matters have been resolved, we now can provide the committee with a summary of the 2014 survey results.

Responses were requested and provided from the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Company,
- CareFirst- including CareFirst BlueChoice, Inc. ("BlueChoice"), CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services ("CareFirst/GHMSI'),
- Cigna ("Cigna")- including Cigna Health and Life, Insurance Company, and Connecticut General Life Insurance Company,
- Evergreen Health Cooperative Inc. ("Evergreen"),

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser"),
- United Healthcare ("United Healthcare")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., United Healthcare Insurance Company, All Savers Insurance Company , and United Healthcare of the Mid-Atlantic, Inc., and
- Freedom Life Insurance Company of America ("Freedom").

The MIA issued six administrative orders based on its investigation findings. Three of the carriers did not contest the orders (Cigna, Aetna/Coventry and Evergreen), and three carriers requested hearings (BlueChoice, CareFirst/GHMSI, and Kaiser). Copies of the orders are attached (*See* Attachment B).

The MIA provides the following summary of the findings, actions taken, and outcome for each carrier referenced above:

Aetna/Coventry:

Coventry's responses revealed the following:

- Aetna/Coventry had no in network psychologists in all of Western Maryland (including Garrett, Allegheny, Washington and Frederick counties). Coventry only had one in-network psychiatrist in Washington County, and no in-network psychiatrists in either Garrett or Allegheny counties. Additionally, there were no in-network licensed professional counselors or licensed clinical social workers in Garrett County.
- There were no in-network methadone treatment centers in the state for Coventry, and only one in-network for Aetna.

The MIA found Aetna's/Coventry's network was insufficient. As a result of these findings, Order# MIA-2015-12-035 was issued to Coventry by the MIA. The MIA directed Coventry to provide quantitative goals for psychiatrists, psychologists, licensed professional counselors and licensed clinical social workers for Garrett County within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days demonstrating in-network access to methadone treatment. Coventry provided the required follow-up documentation. It indicated that Coventry conducted a thorough review of all clinic locations and in-network providers and identified 12 additional in-network methadone treatment clinics. Additionally Coventry provided analysis demonstrating that they met their network accessibility standards with regards to the other provider types.

CareFirst:

For CareFirst, who insured the most Marylanders, the MIA analyzed the responses for both BlueChoice and CareFirst/GHMSI.

BlueChoice's responses revealed the following:

- There were no in-network methadone treatment centers in the state for BlueChoice.
- BlueChoice used a separate vendor to manage the mental health/substance abuse disorder network and therefore there were concerns that reimbursement rates were different than for somatic illness providers.
- Geofactors applied to somatic illness providers were not applied to mental health/substance abuse disorder providers.

The MIA found BlueChoice's network was insufficient. As a result of these findings, Order# MIA-2015-10-036 was issued to BlueChoice by the MIA. The MIA directed BlueChoice to provide documentation within 90 days demonstrating in-network access to methadone treatment, to provide documentation within 90 days outlining the underlying factors used to calculate reimbursement rates for all types of providers, and imposed an administrative penalty of $30,000.00. BlueChoice requested a hearing.

The MIA and BlueChoice negotiated a Consent Order (*See* Attachment C). In response to the Order, BlueChoice entered into a contract with a methadone treatment provider with multiple locations as of December 2015. BlueChoice also provided a notice explaining that mental health/substance use disorder providers are treated as in-network providers for the purpose of reimbursement of this benefit. Finally, it was determined that BlueChoice's policy to apply geofactors on reimbursement rates to providers treating somatic illness and not to mental health/substance abuse disorder providers actually benefitted Maryland consumers. The application of the geofactors would be detrimental and result in lower reimbursement rates for mental health/substance abuse disorder providers, which may discourage new providers to join BlueChoice's network.

CareFirst/GHMSI responses revealed the following:

- CareFirst/GHMSI's availability plan filed with the MIA identified that they had not met the stated goals for network adequacy in two mental health/substance abuse disorder provider groups.

As a result of this finding, Order# MIA-2015-10-034 was issued to CareFirst/GHMSI by the MIA to bring them into compliance. The MIA directed CareFirst/GHMSI to provide documentation within 90 days demonstrating an increase in the number of both neuropsychological doctors, and geriatric psychiatrists in its provider panel, to provide a written update in six months of CareFirst/GHMSI's effort to contract with additional providers.

The MIA entered into a Consent Order (*See* Attachment D), which required CareFirst/GHMSI to provide an updated availability plan that showed members were able to obtain the mental health benefits despite not meeting standards in the identified provider groups. The MIA received the necessary information and has determined that CareFirst/GHMSI is now in compliance.

<u>Cigna:</u>

Cigna's responses revealed the following:

- While Cigna was using the Uniform Credentialing Application for both somatic illness and mental health/substance use disorder providers, they also were requiring screening interviews for the mental health/substance use disorder providers Section 15-112.1(b) of the Insurance Article requires that the Uniform Credentialing Form be the sole application to become credentialed.
- Additionally, Cigna required mental health/substance use disorder provider applicants who had undergone treatment for substance abuse, to be sober for two years. This was not required for somatic illness providers. This information was captured outside of the Uniform Credentialing Application, which does not require such information.
- Cigna required mental health/substance use disorder providers shorter response timeframes to respond to inquiries as opposed to their somatic illness provider counterparts. This finding also indicated that the credentialing was more burdensome for mental health/substance abuse disorder providers.

The MIA found the credentialing differences were more burdensome for providers of mental health/substance abuse disorders. As a result of these findings, Order# MIA-2015-10-007 was issued to Cigna by the MIA. The Order required corrective action within ten (10 days) to eliminate the practice of screening interviews for providers, to allow mental health/substance abuse disorder providers the same amount of time (30 days) to respond to written requests as somatic illness providers, and to pay an administrative penalty of $9,000.00. Cigna filed a corrective action plan, providing documentation that they made the changes to their credentialing standards, removed the prescreening form from the credentialing policy and procedure, revised their policy to allow behavioral practitioners 30 days to respond to written requests for additional information consistent with medical/surgical providers, and paid the administrative penalty.

Evergreen:

Evergreen's responses revealed the following:

- Evergreen utilized two vendors; one vendor for somatic illness providers, and one for mental health/substance abuse disorder providers.
- There was no coordination between the two vendors to ensure that credentialing standards were no less stringent for their somatic illness vendors than their mental health/substance abuse disorder vendors.
- Evergreen did not use the same factors when setting reimbursement rates. Providers who treated somatic illnesses were treated consistently, with reimbursement pricing generally based on a percentage of Medicare rates. Mental health/substance abuse disorder provider reimbursement pricing included a factor relating to a CPT code which was not factored into the reimbursement rate in the same manner for providers who treated somatic illnesses.
- Evergreen reported no in-network psychiatrists, psychologists, licensed clinical social workers or certified professional counselors in Garrett County, Maryland, which demonstrated that their network was insufficient.

As a result of these findings, Order# MIA-2015-10-033 was issued to Evergreen by the MIA. The MIA directed Evergreen to provide a quantitative goal for in-network providers for mental health and substance use disorder benefits within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days of changes to their methodology for provider credentialing and provider reimbursement to comply with the MHPAEA.

The MIA received documentation from Evergreen that their behavioral health provider network (Beacon) includes providers whose offices are located within the required geographical proximity of members who reside in Garrett County. Evergreen permitted members who were unable to access a participating provider within the required geographic proximity, to be treated by an out-of-network provider while utilizing in-network benefits. The mental health vendor contacted 15 mental health/substance use disorder providers within Garrett County in an effort to enlarge the number of in-network providers, with limited success. They also reported that while their two vendors use different methodologies to negotiate rates with providers, they apply the same reimbursement factors in the same fashion. The MIA received the information it requested from Evergreen.

Kaiser:

Kaiser's initial responses indicated the following:

- Kaiser had 28 in-network licensed professional counselors for their entire Maryland service area which resulted in a provider to member ratio of 1/5,927. This ratio was less favorable to members than for other mental health/substance abuse disorder provider types within Kaiser's network.

As a result, Order#MIA-2015-10-035 was issued by the MIA to Kaiser. The MIA directed Kaiser to provide numeric goals for in-network licensed professional counselors within 90 days to ensure an adequate network, and to provide a written update whether the goal had been met in six months. Kaiser provided the MIA additional information that illustrated that there was no unreasonable delay to receive care. The MIA concluded that Kaiser's network was not insufficient. The MIA rescinded its Order.

United Healthcare:

The MIA's review of United Healthcare's practices revealed no MHPAEA violations based on the Maryland Insurance Article.

Freedom:

In its response to Survey One, Freedom disclosed that it did offer qualified health plans in the individual or group markets in Maryland. The survey questions were therefore not applicable to Freedom and the Administration closed its investigation.

We hope this summary information is helpful and we would be glad to provide any further information about the results of Survey One upon request.

In addition, you asked that the MIA monitor and update the committee on efforts in other states, in particular California. California's Department of Managed Health Care ("DMHC") requires full service health plans (that offer commercial coverage for individuals, small groups, or large groups in 2015) to submit filings that demonstrate their compliance with the MHPAEA. In 2014, the DMHC provided insurers with detailed instructions that required them to complete worksheets that compare their behavioral health coverage to other medical coverage, and required them to complete another worksheet comparing their application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

In 2013, the DMHC fined Kaiser $4 million, in part, because the DMHC found Kaiser and its providers were informing consumers that certain mental health services were not covered, which was in direct violation of the parity sections of California's state laws. In this follow-up report the DMHC determined that Kaiser had not adequately corrected this violation. The Department found that while Kaiser had corrected this information on its website and in its explanation of benefits documents, its providers were still telling consumers that certain medically necessary services were not covered, like long-term therapy. The report indicated that the Department is considering further disciplinary action.

In 2014, the DMHC reached a settlement with Health Net of California for $300,000 after initially issuing a cease and desist order in November 2013. Among other accusations, Health Net was accused of "failure to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions." This was in violation of the parity provisions within the Health and Safety Code.

Several fines were levied due to carriers' behavioral health coverage practices, notably: Oregon's Department of Consumer and Business Services fined Health Net of Oregon $5,000 dollars for denying coverage for behavioral health services because the patients did not get prior authorization from Health Net; Missouri's Department of Insurance, Financial Institutions and Professional Registration reached a $4.5 million settlement with Aetna for its continued failure to provide coverage for autism services in compliance with state law; the Connecticut Insurance Department recovered $1.3 million for consumers from insurance plans after investigating complaints about health insurance coverage - some of these complaints were about behavioral health coverage, and Vermont's Department of Financial Regulation fined Cigna Behavioral Health $392,500 after it was found that Cigna had used the recommendations of "unlicensed review agents" in making coverage determinations.

Other states are initiating other action, including:

- Connecticut is creating a short consumer guide and a behavioral health consumer toolkit to help consumers navigate the appeals process and better understand how to get quality behavioral healthcare through their insurance plans,

- Rhode Island's Office of the Health Insurance Commissioner, after receiving complaints from consumers that insurance plans were not covering needed behavioral health services, initiated market conduct examinations on four insurers to see if they are violating parity laws, and
- the Massachusetts Division of Insurance ("DOI") commissioned a report that found that behavioral health patients on average have to wait much longer for follow-up care than non-behavioral health patients, and, although the delays were not necessarily caused by federal or state parity law violations, the report recommended that the DOI should create standards for the detail required in insurance company records about follow-up care so that it is easier to see if there are differences in the utilization management process for behavioral health patients versus non-behavioral health patients. We are monitoring this action.

We hope this information is helpful.

Finally, you asked that the MIA examine the extent to which contract and plan benefit design features, financial requirements, treatment limitations, and utilization review requirements, as well as carrier processes, standards, and factors used to administer benefits, change from year-to-year to evaluate the feasibility of the prospective reporting that would have been required under SB 586. Please note that MIA staff reviews annually on a prospective basis many of the items listed in SB 586. Under MHPAEA, the financial requirements are required to be based on assumptions for the next year, so annual verification is needed and is performed during the annual contract review in the individual and small group markets. Also, due to the filing requirements under the Affordable Care Act, we are seeing new cost-sharing requirements for benefits being filed for the individual and small group markets annually so that the plans can continue to meet to required metal levels. Therefore, for contract review, MIA staff is already reviewing prospectively contracts for approval, including the contract and plan benefit designs, financial requirements, and permissible exclusions and limitations.

The MIA worked with the various interested parties to develop a second survey to address additional concerns regarding compliance with MHPAEA. Survey Two was sent to the health insurance carriers on October 20, 2015. (*See* Attachment E.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Two analysis once it has been completed. We will be working with interested parties to develop a third survey to be sent out this year.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Peter A. Hammen, Chairman, House Health and Government Operations Committee
Cc: Patrick Carlson, Senate Finance Committee Staff
Cc: Linda Stahr, HGO Committee Staff
Cc: Nancy J. Egan, Esq., Director of Government Relations, MIA
Attachments: (5)

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January 26, 2018

Sent Via Certified and Electronic Mail

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with the final results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

On June 30, 2017, the MIA submitted a summary of the 2015 Survey findings to your attention. *See* Attachment A. That summary explained that investigations were ongoing for UnitedHealthcare ("UHC" including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.) and CareFirst (including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI")). The MIA has completed those investigations, as detailed below. Information about UHC, BlueChoice, CareFirst of Maryland Inc., and GHMSI's provider networks that was received during the 2015 Survey was included in the letter the Administration sent to your attention on June 30, 2017. *See* Attachment A, Section "Provider and Facility In-Network Adequacy."

UnitedHealthcare ("UHC")

UHC's responses to the MIA's 2015 survey and resulting investigation revealed that UHC's managed behavioral health organization United Behavioral Health Inc., under the brand Optum, reviewed a five year malpractice history for all mental health/substance use disorder facilities applying to be credentialed. UHC collected but did not review a malpractice history for any medical/surgical facilities.

As a result of finding that UHC applied more stringent credentialing requirements to behavioral health facilities than to medical/surgical facilities, Consent Order # MIA-2017-08-009 was issued to UHC by the MIA to bring UHC into compliance. *See* Attachment B. The MIA directed UHC to pay a fine of $2,000.00 for the four behavioral health facilities affected by this practice, and to submit, within 30 days, a corrective action plan. UHC has paid the fine and has removed the requirement to review a five year malpractice history for mental health/substance use disorder facilities.

CareFirst

On May 1, 2017, the MIA became aware that CareFirst BlueChoice, Inc.'s ("BlueChoice") online provider directory for behavioral health listed only two of the 27 in-network mental health hospitals and two of the seven mental health non-hospital facilities that the Respondents had reported were in-network during the MIA's investigation. The MIA was informed that the 27 hospitals include acute care/general hospitals that were listed under the medical/surgical portion of the provider directory. Additionally, two of the non-hospital facilities that were reported were listed only under the medical/surgical portion of the provider directory. The remaining three non-hospital facilities that were reported were not listed anywhere in the provider directory. In response to the MIA's investigation, BlueChoice corrected the error with its online provider directory. All reported facilities are now listed in the behavioral health provider directory as well as the medical/surgical directory if the facilities provide both services.

On May 1, 2017, the MIA also became aware that CareFirst BlueCross BlueShield's Blue Preferred online behavioral health provider directory did not list any in-network inpatient mental health facilities. The MIA was informed that the inpatient mental health facilities appeared in the directory under the medical/surgical portion of the provider directory. In response to the MIA's investigation, CareFirst BlueCross BlueShield corrected the error with the Blue Preferred online behavioral health provider directory to reflect that there were seven in-network facilities.

As a result of the inaccuracies in BlueChoice and CareFirst BlueCross BlueShield's online provider directories, Consent Order # MIA- was issued to CareFirst by the MIA to bring CareFirst into compliance. *See* Attachment C. The MIA directed BlueChoice to pay an administrative penalty of $20,250.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. BlueChoice has paid the fine and corrected its directory as of December 11, 2017. The same consent order directed CareFirst BlueCross BlueShield to pay an administrative penalty of $4,725.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. CareFirst BlueCross BlueShield has paid the fine on January 5, 2018, and corrected its directory as of May 5, 2017.

Survey Three

The MIA worked with various interested parties to develop a third survey to address additional concerns regarding compliance with MHPAEA. Survey Three was sent to the health insurance carriers on October 6, 2017. (*See* Attachment C.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Three analysis once it has been completed.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chair, House Health and Government Operations Committee
Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

– Attachment A

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

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June 30, 2017

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with an update on the results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and addiction parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully-insured group and individual health benefit plans ("2014 Survey"). (*See* Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (*See* Attachment B).

In preparation for developing and issuing the second survey ("2015 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 26, 2015. The 2015 Survey was sent to the carriers on October 20, 2015, and is attached for your review. (*See* Attachment C). All of the carriers responded.

Responses were requested of and provided by the following carriers:[1]

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI");
- Cigna Health and Life Insurance Company ("Cigna");
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Kaiser);
- United Healthcare ("UHC")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.; and
- Freedom Life Insurance Company of America ("Freedom").

In October, 2016, the MIA was awarded a federal grant which funded an extra staff member to continue the second MHPAEA survey analysis and to conduct investigations of possible violations. The MIA has completed its review of the survey results for Aetna, Cigna, Kaiser, and Freedom. A review of Aetna's, Cigna's and Kaiser's practices revealed no violations of the MHPAEA or applicable state mental health and substance use disorder parity laws. In its response to the 2015 Survey, Freedom disclosed that it did not offer qualified health plans in the individual or group markets in Maryland. The survey questions therefore were not applicable to Freedom and the Administration closed its investigation.

The MIA has not yet completed its review of UHC and CareFirst. The MIA will provide you with its findings when these reviews are completed.

Issues Corrected During the Investigation

As a result of the survey, a number of issues were identified and corrected during the Administration's investigation. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents and/or no harm to consumers was identified. The following errors were corrected:

- Internal medical review policy limited disclosure of the medical/surgical medical necessity guidelines to three guidelines at a time to a provider/member. The carrier believed that its licensing agreement for the guidelines required it to limit disclosure of the guidelines. As a result of the MIA's investigation, the carrier reviewed its licensing agreement and determined that the limitation was not in the agreement. The carrier removed the limitation from its internal medical review policy. The carrier informed the MIA that it was not aware of any requests for the guidelines that had been denied or limited because of the internal policy.

- Financial testing for a large group plan did not account for all of its outpatient benefits in the "all other outpatient" category nor preventative benefits in the out-of-network outpatient office visits category. As a result of the MIA's investigation, the carrier corrected its financial testing and

[1] Evergreen Health Cooperative Inc., was also surveyed and provided a response to the 2015 Survey. Due to the Company's ongoing efforts to remain viable in the marketplace during the span of the 2015 Survey, Evergreen was removed from examination. As a result, no further investigation was conducted following Evergreen's initial survey response. The MIA will consider reopening investigations upon commencement of the third parity survey.

demonstrated that the exclusions of certain benefits did not change the results of the cost-sharing that could be applied to mental health/substance use disorder benefits in those classifications.

- An online provider directory indicated that it did not have any in-network inpatient facilities that could treat mental health illnesses. As a result of the MIA's investigation, the carrier corrected its online directory to reflect that there are in-network inpatient facilities to treat mental health illnesses.

- A publically available document demonstrating compliance with MHPAEA ("MHPAEA Summary") provided that the carrier's credentialing process for medical/surgical providers required the provider to agree to a site visit *if* required by the credentialing committee. In contrast, the carrier's managed behavioral health organization ("MBHO") *required* a site visit for each mental health/substance use disorder provider applying to be credentialed. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to site visits for credentialing. The carrier and MBHO confirmed that they do not require site visits as part of credentialing for their commercial networks. As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to reflect this information.

- The MHPAEA Summary also provided that for out-of-network inpatient scheduled admissions there are two different notice requirements to obtain prior authorization, (1) "as soon as possible" and (2) "5 days before receiving the benefit." The MHPAEA Summary stated that all scheduled admissions for inpatient mental health/substance use disorder treatment must obtain prior authorization "as soon as possible." In contrast, the only example of a medical/surgical treatment that was held to that requirement was transplants. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to out-of-network inpatient prior authorization requirements. The carrier confirmed that all scheduled out-of-network admissions for medical/surgical and mental health/substance use disorder benefits were required to obtain prior authorization "as soon as possible." As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to accurately reflect its procedure.

Provider and Facility In-Network Adequacy

In the 2015 Survey, the MIA requested responses to the following questions regarding in-network providers for inpatient and outpatient treatment of heroin and opioid abuse disorders, diabetes, stroke, and bipolar disorders:

a) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.

b) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).

c) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.

d) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.

Some carriers reported that they do not have in-network non-hospital facilities for the treatment of heroin/opioid abuse disorders and bipolar disorder in certain counties of Maryland.[2] Other plans did not have any in-network inpatient hospitals, inpatient non-hospital facilities, or intensive outpatient treatment for substance use disorder treatment or bipolar disorder treatment in certain counties. [3]

As a result of the MIA's investigation, some carriers entered into new contracts with facilities located in counties lacking in-network providers. However, carriers advised the MIA that although they continue efforts to recruit providers and facilities in these counties, there do not appear to be any licensed non-hospital based behavioral health inpatient facilities that are willing to contract with managed care plans in many counties. Some carriers also provided information demonstrating that they meet their network accessibility standards with regards to all provider and facility types despite the lack of in-network facilities in certain counties. Other carriers address the shortage of in-network providers by (1) allowing members to access out-of-network providers at their in-network cost-sharing rate and (2) authorizing continued acute inpatient care until it is safe to transition the patient to partial hospitalization or intensive outpatient treatment.

Other State MHPAEA Compliance Efforts

California.

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that California's Department of Managed Health Care ("DMHC") required full service health plans (that offer commercial coverage for individuals, small groups, or large groups) to submit filings in 2014 that demonstrate the carriers' compliance with the MHPAEA for health plans sold in 2015.[4] In 2014 and 2015, the DMHC penalized two insurers for violations of state and federal parity laws. Those actions were addressed in more detail in the MIA's Summary Letter for the 2014 Survey, included as an attachment for your convenience. (*See* Attachment B). Additionally, the DMHC conducted a desk audit to review the filings. The desk audit resulted in 24 plans out of 25 lowering MH/SUD cost-sharing in one or more products; 3 plans eliminating impermissible day or visit limits on MH/SUD benefits; 12 plans modifying or clarifying prior or concurrent authorization requirements; and all 25 plans revising their evidence of coverage text to more clearly describe MH/SUD benefits.

On April 1, 2016, following the desk audit, the DMHC began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC is also looking at plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.[5]

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[2] Counties reportedly lacking in-network heroin/opioid treatment facilities: Calvert, Charles, St. Mary's, Allegany, Garret, and Washington counties. Counties lacking in-network bipolar treatment facilities: Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot counties.

[3] Counties reportedly lacking in-network heroin/opioid providers: Garrett, Queen Anne's and Worchester counties. Counties lacking in-network bipolar disorder providers: Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester counties.

[4] New Hampshire and the federal Center for Medicare and Medicaid Services have used the workbooks developed by DMHC when conducting their own market conduct exams.

[5] Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

The DMHC finished its first round of audits in early 2017. It plans to issue reports to the carriers in the first half of 2017.[6] Preliminary findings released by the DMHC include continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

Beginning in 2016, the California Department of Insurance (CA DOI) required carriers to complete Parity Workbooks as part of each carrier's 2017 plan filling. The Workbook provides insurers with detailed instructions that require them to complete worksheets that compare financial and quantitative treatment limitations applied to their behavioral health coverage to other medical coverage. Another required worksheet compares the insurers' application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

Checklists and Carrier Attestations.

Many states, including Maryland, rely on checklists and carrier attestations that plans are complying with state and federal parity laws.[7] These checklists and attestations are required as a part of a state DOI form review prior to the plan being sold on the market. Some checklists are simple, merely stating that the plan must comply with state and federal parity laws and providing a box in which the carrier is meant to cite to the form page that supports this requirement. Others require more in-depth information be provided including a narrative description of the methodology used to determine plan parity compliance and completed worksheets demonstrating parity compliance for financial and quantitative treatment limitations.[8] Fewer states conduct a comprehensive review of non-quantitative treatment limitations during form review.

Data Collection and Targeted Market Conduct Examinations.

Nine states undertake targeted market conduct examinations ("MCEs") focused on behavioral health benefits and initiated as the result of consumer complaints or information collected during form review.[9] These MCEs have resulted in penalties and corrective action plans.[10] Some states have completed MCEs focusing on compliance with federal and state parity laws. Notably, New Hampshire's DOI completed

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[6] The DMHC will make final reports available to the public on the DMHC's website. The DMHC intends to complete the remaining 20 surveys in June 2017.

[7] States with this requirement include Alabama, Alaska, California, Colorado, Connecticut, Delaware, Indiana, Maine, Maryland, Massachusetts, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, and Washington.

[8] California, Connecticut, Maryland, Massachusetts, Rhode Island.

[9] California, Connecticut, New Hampshire, New York, North Dakota, Pennsylvania, Rhode Island, Washington, West Virginia.

[10] In 2011, West Virginia's Office of the Insurance Commissioner fined insurance plans $115,305.79 for violations related to the state parity law discovered during market conduct exams. In 2014, North Dakota DOI determined that its BlueCross BlueShield improperly denied 63 MH/SUD claims because it failed to comply with utilization review guidelines, medical necessity guidelines, and/or its contracts and state law. BCBS agreed to correct its procedures. In 2015, Connecticut DOI fined United Behavioral Health $8,500 and required United to submit a plan for compliance within 90 days after a MCE determined that 2 appeal determinations were not reviewed by an appropriate clinical peer for the service requested. Other MCE and resulting fines were detailed in the MIA's 2014 Survey Summary, attached for your convenience. (*See* Attachment B).

three MCEs of Anthem Health Plans of New Hampshire, Inc. ("Anthem"), Cigna Life and Health Insurance Company ("Cigna"), and Harvard Pilgrim Health Care of New England, Inc. ("Harvard Pilgrim").[11] These targeted MCEs included review of issuer compliance with MHPAEA and focused on substance use disorder benefits. In 2017, the New Hampshire DOI ordered Anthem, Cigna, and Harvard Pilgrim to correct various issues including inadequate provider networks for MH/SUD services, inaccurate provider directories, and accessibility problems. As a result, Anthem added 100 new MH/SUD provider contacts and developed the Aware Recovery Care Program, a team-based approach to treat substance use disorder. Additionally, Anthem and Harvard's improper dosage limitation on Evizo, the naloxone auto-injector used to prevent overdoses, was highlighted for correction. New Hampshire's DOI plans to open targeted MCEs into Anthem's credentialing criteria and an additional follow up examination of Harvard's reimbursement methodology and rates.

Another developing method used by states to monitor parity compliance is data collection and examination.[12] The data is examined for patterns that may indicate an underlying parity violation that should be investigated through an MCE. There were two states that had significant findings. In 2016, New Hampshire's DOI used its all-payer claims database to analyze provider reimbursement rates for substance use disorder services for 2014 and 2015. New Hampshire determined that commercial carriers consistently paid health care providers less than Medicare rates for treating patients with substance use disorders. The New York Office of the Attorney General ("NY OAG") examined denial rate data as part of its investigations into carrier compliance with state and federal parity laws. The denial rate data showed that carriers denied some behavioral health claims up to seven times as often as medical/surgical claims in the same category.[13] Based in part on the data it reviewed, the NY OAG issued an order against Excellus Health Plan, Inc. ("Excellus") finding, among other parity violations, that it "applies more rigorous—and frequent—utilization review for inpatient substance use disorder treatment than for inpatient medical/surgical treatment." The NY OAG made the same determination about ValueOptions' utilization review practices, finding that it issued denials for behavioral health claims twice as often and addiction recovery services four times as often as medical/surgical claims. At least four New York health plans subcontract with ValueOptions to administer their member's behavioral health benefits. Between 2014 and 2015, the NY OAG reached settlements with six health insurance carriers, ordering corrective action and assessing approximately $4.6 million dollars in fines and penalties.

Massachusetts requires carriers to annually submit data that compares MH/SUD services and M/S services in areas including number of requests for authorization of services and type of services; authorization requests approved, modified, and denied; the number of internal appeals and outcome; and number of appeals sent to external review and outcome. Representatives of the Massachusetts Department of Insurance advised the MIA that the data is being used to track areas of concern for future MCEs.

Utilization and Medical Necessity Review Criteria.

There is an emerging trend in the states focused on standardizing utilization review criteria for substance use disorder benefits. At least four states now require carriers to use the nationally recognized

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[11] In order to conduct these MCE, New Hampshire DOI contracted with an IRO and a pharmacist to assist with review of medical necessity denials and prescription formularies.

[12] States that have employed this method include Connecticut, Massachusetts, New Hampshire, New York, and Vermont.

[13] Excellus Health Plan, Inc. issued denials in 48% of the inpatient substance use disorder treatment reviews it conducted for preauthorization compared to less than 20% of the inpatient medical/surgical requests. Additionally, 29% of outpatient behavioral health services were denied compared to 13% of outpatient medical/surgical services.

American Society of Addiction Medicine ("ASAM") utilization review criteria and medical necessity review criteria when managing substance use disorder benefits for private insurance products.[14] Connecticut also requires carriers to use criteria established by the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument when reviewing requests/claims for child/adolescent mental disorder services, and the American Psychiatric Association Guidelines or Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare for adult mental disorder services.[15] The Connecticut law does allow carriers to develop their own criteria or purchase criteria from other qualified vendors approved by the DOI in order to address advancements in technology/types of care that are not covered in the most recent guidelines/criteria listed in the statute.

Future Plans.

The MIA is currently developing a template for future parity MCEs by drawing from its own experience with the parity surveys and investigations, other states' MCEs, and the NAIC's Market Regulation Handbook. A third parity survey is also under development. The MIA intends to invite interested parties to a meeting on August 21, 2017, to engage in a discussion regarding the third survey.

If you have any questions about this summary letter or any other activities undertaken by the MIA with reference to the parity surveys, please call me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee
Linda Stahr, Committee Counsel
Partick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

[14] Connecticut, Illinois, New Hampshire, Rhode Island.
[15] S.B. No. 372, effective January 1, 2017 and codified at § 38a0591c of Connecticut's insurance law.

LAWRENCE J. HOGAN, JR.
Governor

BOYD K. RUTHERFORD
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September 18, 2019

The Honorable Delores G. Kelley
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015- Summary of Survey Three Analysis

Dear Senator Kelley:

The purpose of this letter is to provide you with an update on the results from the third survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and substance use disorder parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and substance use disorder parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully insured group and individual health benefit plans ("2014 Survey"). (*See* Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (*See* Attachment B).

In October 2015, the second survey was sent to carriers. (*See* Attachment C). The second survey revealed violations and the MIA issued two administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 30, 2017, and January 26,

2018, the MIA submitted summaries of the 2015 Survey findings to your attention. (*See* Attachment D and E).

In preparation for developing and issuing the third survey ("2017 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 21, 2017. The 2017 Survey was sent to the carriers on October 6, 2017, and is attached for your review. (*See* Attachment F). All of the carriers responded.

Responses were requested of and provided by the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst ("CareFirst")- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI");
- Cigna Health and Life Insurance Company ("Cigna");
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Kaiser);
- United Healthcare ("UHC")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.

The MIA has completed its review of the survey results for all of the above listed carriers. The Administration did not identify any violations of MHPAEA or the applicable state mental health and substance use disorder parity laws during its investigations of Kaiser and CareFirst. The investigation of UHC is ongoing and the results of that investigation will be reported when complete.

Orders Issued

Aetna

Aetna's responses revealed the following:

- Aetna's internal policy document governing the assessment and credentialing of organizational providers required inpatient and outpatient behavioral health facilities to complete detailed Personnel Review assessments that were not required to be completed by Medical/Surgical inpatient and outpatient facilities.

The MIA asked Aetna to explain the difference in the credentialing requirements for behavioral health and M/S facilities. Aetna responded that it agreed there was a discrepancy and that Aetna would add a Personnel Review section to the Medical/Surgical facility assessments. The MIA found that Aetna's written policy did not comply with MHPAEA. As a result of these findings, Consent Order # MIA-2018-10-037 was issued to Aetna by the MIA. The MIA directed Aetna to provide a correct internal policy document including a Personnel Review section for credentialing Medical/Surgical facilities simultaneously with executing the consent order. Additionally, the MIA fined Aetna $1,500 for the three

behavioral health facilities that have undergone the more burdensome Personnel Review assessment as a part of Aetna's facility credentialing process since the final MHPAEA rules went into effect. Aetna paid the fine and submitted a corrected policy to the MIA, resolving the consent order.

Cigna

Cigna's responses revealed the following:

- In 2017, Cigna denied five of the thirteen behavioral health facilities that applied to join its network for the reason that "no network need identified." Cigna did not deny any of the 122 medical/surgical facilities that applied from 2015-2017 for that reason.

The MIA asked Cigna to explain what factors and evidentiary standards it used to determine "no network need identified," for behavioral health facility applications and to demonstrate that those factors and evidentiary standards were applied comparably and just as stringently to medical/surgical facility applications. Cigna was not able to provide support for why five behavioral health facilities but no medical/surgical facilities were denied for this reason, based on the factors that Cigna considers when admitting a facility to its network. Cigna stated that its decision to admit or deny a facility entrance to its network is based in part on discretion. The MIA found that Cigna more stringently applied discretion in determining that "no network need identified" for five behavioral health facilities that applied to join its network in 2017.

As a result of these findings, Consent Order # MIA-2019-06-012 was issued to Cigna by the MIA. The MIA directed Cigna to provide a corrective action plan for its review and admission of facility applications to its network that demonstrates that behavioral health and medical/surgical facilities are reviewed in a parity compliant manner. That corrective action plan is due to the MIA in September 2019. Additionally, the MIA fined Cigna $25,000 for having a process that violated MHPAEA. Cigna signed the Consent Order and paid the fine.

Issues Corrected During the Investigation

As a result of the survey and resulting investigations, a number of issues were identified and corrected. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents. The following errors were corrected:

- An internal concurrent review policy stated that for Indemnity and Traditional Choice plans, "[c]oncurrent review is not a requirement for medical inpatient admissions. Behavioral health inpatient and residential admissions for [carrier] members do include concurrent review." The carrier explained that "[t]his policy statement was in error and was not in keeping with operational practices. . .both medical/surgical and behavioral health [] perform concurrent review if notified of an inpatient admission." The carrier provided a copy of the updated policy with the correction and data supporting that

concurrent review did occur for medical/surgical inpatient admissions for Indemnity and Traditional Choice plans during the examination period.

- An internal policy which contained a list of services that require pre-authorization stated that "All Behavior [sic] Health Services" required pre-authorization. There was no similar requirement of pre-authorization for all medical/surgical services. The carrier explained that the policy was misleading and that pre-authorization requirements are identical for medical/surgical and behavioral health services. All inpatient services require pre-authorization (with the exception of emergency services). Outpatient services require pre-authorization depending on the product the member purchased and the network with which the provider participates, not based on the services provided. The carrier corrected its internal policy to clarify that medical/surgical and behavioral health services have identical pre-authorization requirements.
- An internal policy describing when an exception will be approved to access care out-of-network under Maryland Insurance Article § 15-830(d) did not include an exception for when an appropriate provider is not available without unreasonable delay. The carrier explained that it does consider this fact when granting out-of-network exceptions and supported its position by providing data that showed the number of exception requests granted for the reason that an appropriate provider was not available without unreasonable delay during the examination period. The carrier corrected its internal policy document to include this exception.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities stated that all such facilities would be interviewed as a part of the credentialing process. No similar interview requirement was included in the internal policy document describing the requirements and standards for facility credentialing of M/S facilities. The carrier explained that the MH/SUD should not have had an interview requirement as that does not accurately reflect the credentialing process. The carrier attested that both MH/SUD and M/S facilities are contacted during contracting to clarify the services the facility provides for reimbursement purposes. The carrier corrected its internal policy document to remove all mention of an interview requirement.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities did not include a similar process for obtaining an exception to the requirements of submitting a malpractice history or meeting the liability insurance requirements as are contained in the M/S facility credentialing policy. The carrier explained that this was inadvertent and that the exception processes are similarly available for all facility types. The carrier provided a corrected facility credentialing policy for MH/SUD facilities that included descriptions of the exception process. The carrier noted that the exception process is not disclosed to the facilities in the credentialing application; therefore, no facilities were unfairly notified of the availability of an exception process. The carrier confirmed that most facilities utilized the exception process for disclosing malpractice history based on advice of legal counsel and zero facilities utilized the exception process for the liability insurance requirements during the survey period.
- An internal concurrent review form for inpatient mental health services contained an authorization guideline that stated the maximum number of days the clinical reviewer could approve was 7 days per utilization review. No similar maximum day cap was mentioned in any of the provided internal utilization review forms for medical/surgical

services. The carrier explained that there is no actual cap on the number of days the clinical reviewer can approve at one time for any behavioral health inpatient services. The carrier attested that both the M/S inpatient Goal Length of Stay and MH/SUD inpatient limit to a maximum number of days that can be approved are developed based on evidence based treatment guidelines. Both are guidelines and not rules, and exceptions to both M/S and MH/SUD suggested number of inpatient days can be made when the individual member's circumstances demonstrate that a different number of days are medically necessary. There is no operational/computer barrier to approving more than the maximum number of days suggested for MH/SUD inpatient services.

Internal Review Process for MHPAEA Compliance

In the 2017 Survey, the MIA asked carriers about the delegation of development/management of behavioral health benefits to another entity, the oversight the carrier exercised over that entity, the audits the carrier conducted to determine compliance with nonquantitative treatment limitation (NQTL) rules, specifically utilization management standards, both as written and in operation.[1]

All of the carriers who reported delegating the management of behavioral health services to another entity provided the delegation agreements which established routine audits of the delegate's internal policies and processes. None of these delegation agreements specifically addressed assessing MHPAEA compliance.

All of the carriers reported at least an annual review of plan documents and internal policies and procedures for MHPAEA compliance. However, the stringency of the MHPAEA review varied between carriers. Some carriers reported MHPAEA assessments but were not able to provide any written policies establishing such an assessment or any written reports documenting the results of such an assessment. Other carriers produce an annual MHPAEA document, focusing on a side-by-side comparison of medical/surgical and behavioral health NQTLs based on review of plan documents and internal policies and procedures. However, most of those carriers were not able to provide any written policies establishing the processes undertaken to produce this side-by-side comparison and lacked any review of MHPAEA compliance in operation. A couple of the carriers attested that the companies were working to establish a team to conduct MHPAEA audits, focusing on determining whether NQTLs were no more stringent in operation, which has not yet been assessed by most carriers. One carrier does have a team that conducts at least annual MHPAEA compliance review of written policy documents and reviews operational data to determine whether NQTLs are applied more stringently in operation.

Denial and Appeal Rates

The MIA asked the carriers to provide data on utilization review denials and appeals based on medical necessity between January 1, 2015 and December 31, 2017. *See* Attachment F, Question 6.

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[1] *See* Attachment F, Questions 1 and 2.

Overall, the data carriers provided demonstrated that the number of MH/SUD utilization review requests is significantly lower than the number of M/S utilization review requests at every level of care. For example, one carrier reported that behavioral health utilization review requests made up only .2% of utilization review for all outpatient services.

The data provided by most of the carriers demonstrated comparable rates of utilization review denials within a particular classification of benefits,[2] or, the percentage and number of MH/SUD denials were significantly lower than M/S denials. One carrier did report data that demonstrated that a higher percent of MH/SUD (more frequently SUD) services in the inpatient classification were denied based on medical necessity than M/S services in the same classification. However, overall, MH/SUD utilization review requests for that carrier were denied far less frequently than M/S utilization review requests. The MIA conducted a thorough review of the carrier's internal policies and procedures regarding utilization review and development of medical necessity criteria and did not identify any MHPAEA violations. Although this data may indicate a more stringent application of utilization review to inpatient MHPAEA services in operation, federal guidance on MHPAEA cautions that "[d]isparate results alone do not mean that the NQTLs in use do not comply with [MHPAEA] requirements."[3] However, the most recent guidance released by the federal Department of Labor explains, "[w]hile outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance."[4] The Administration has taken this guidance into consideration for future focused examinations of the carrier.

Credentialing Data

Some carriers reported data that demonstrated that it took longer to credential a MH/SUD facility than a M/S facility between 2015 and 2017. When asked to explain why this occurs, carriers provided the following reasons:

- Agreements with MH/SUD providers each require individual negotiation based on the unique set of services offered by that provider. Each MH/SUD provider's program varies based on the credentials of the individuals providing services (i.e., MD, LSW, RN, etc.), the ratio of providers to patients (i.e., individual versus group and size of group), and the program length of time. Accordingly, unlike for medical/surgical providers who predominantly provide the same type, credentials, ratio and program length, there is little to no industry standard reimbursement rates available for these MH/SUD services. Provider-specific rate negotiations are therefore required and may extend the negotiation period.
- MH/SUD facilities did not submit complete applications.
- MH/SUD facilities required site visits because the facility was not accredited.

[2] MHPAEA dictates that the parity analysis be conducted with each of six classifications: in-patient in-network; in-patient out-of-network, out-patient in-network, out-patient out-of-network, emergency, and pharmacy. 45 C.F.R. § 146.136(c)(2)(ii).
[3] 78 FR 68245.
[4] *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, U.S. Dep't of Labor, Spring 2018, page 17, available at, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf

Importantly, there was not a unanimous trend of carriers taking longer to credential MH/SUD facilities than M/S facilities. Some carriers took far longer to credential M/S facilities than MH/SUD facilities.

As a part of the MIA's work on the Finance Subcommittee for the Governor's Commission to Study Mental and Behavioral Health, the MIA is looking at all aspects of network inadequacies, including barriers to providers and facilities credentialing with carriers. The MIA plans to incorporate what it learned from this survey into the work of the Subcommittee and hopes to address timeliness of credentialing for behavioral health facilities through its work on the Commission.

Out-of-Network Utilization

All of the carriers reported data demonstrating that members accessed behavioral health services out-of-network more frequently than medical/surgical services between 2015 and 2017. Tables showing the top three services and top three diagnoses, for each carrier, that accessed care out-of-network are included in Appendix A. When asked about the higher out-of-network utilization for behavioral health, the carriers provided the following reasons:

- Despite best efforts, MH/SUD providers are less likely to want to join any commercial carrier network than M/S providers. This is a national problem (citing JAMA Psychiatry, 2014 Feb; 71(2): 176-188 as supporting that nationally approximately 50 percent of psychologists do not contract with any insurer, including Medicare).
- Mental Health practices tend to be smaller and do not have the administrative support to file claims or the capacity to accept new patients for extended periods of time, therefore, they do not contract with any insurer.
- Many of the out-of-network claims are laboratory tests.
- There has been growth of a significant industry of SUD providers who offer out-of-network services that are not evidence based treatment and who engage in recruitment practices that prey on vulnerable populations and lure them out-of-network.
- Members may have out-of-network benefits and choose to seek treatment from an out-of-network provider.

On December 8, 2017, the Administration published final regulations for network sufficiency standards.[5] These regulations require carriers to annually report to the Administration how their various networks meet the standards as detailed in the regulations. The regulation includes standards for behavioral health facilities and providers.[6] The standards became effective on January 1, 2018, and the Administration is hopeful that these requirements for behavioral health providers and facilities will address the concerns about inadequate networks for behavioral health services. The Administration plans to continue working on this issue through its enforcement of the Network Adequacy regulations.

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[5] http://www.mdinsurance.state.md.us/Documents/newscenter/legislativeinformation/31.10.44-NetworkAdequacy-FinalPublished1282017.pdf

[6] COMAR 31.10.44.04-06.

Utilization Management and Prescription Drugs

All of the carriers surveyed demonstrated compliance with Md. Ins. Art. §§ 15-850 and 851, by providing coverage for at least one formulation of an opioid antagonist without prior authorization and not having prior authorization requirements for any prescription included in the carrier's formulary that is used to treat opioid use disorder and contains methadone, buprenorphine or naltrexone.

The Administration asked the carriers to provide data from 2015- 2017 regarding prior authorization requirements and denials for SUD, MH, and M/S prescriptions. Additionally, the carriers were asked for data reflecting how many prescription requests were dispensed as a different medication than the medication described. Some carriers provided data that indicated that a higher percentage of SUD prescriptions were subject to utilization review than M/S prescriptions. The instances of utilization review plummeted in 2017, as a result of §§ 15-850 and 15-851, to below or equal to the frequency of M/S prescription utilization review.

One carrier reported data that demonstrated that MH prescriptions were more frequently dispensed as alternate medications than M/S or SUD. This number changed in 2017 to be more equitable between M/S, MH and SUD. The carrier explained that it had moved from an open formulary to a closed formulary and it took providers some time to learn to prescribe medications contained in the closed formulary. The carrier maintained that this is why the numbers leveled out in 2017.

The Administration has reviewed the carriers' utilization review policies for their pharmacy benefits and found that the carriers use the same processes for developing the utilization review requirements and implementing those requirements for M/S and MH/SUD benefits. Although the frequency of SUD prescription utilization review appears to have been corrected by §§ 15-850 and 15-851, further investigation of utilization review files with the assistance of a pharmacist with experience in behavioral health would be necessary to determine if the carrier applied utilization review requirements more stringently to behavioral health medications in operation. The Administration is working on a Request for Proposals to contract with a clinician group who can provide clinical expertise on a variety of Administration examinations, including further review of this issue.

Other State MHPAEA Compliance Efforts

California

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that on April 1, 2016, following a desk audit, California's Department of Managed Health Care ("DMHC") began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC also looked at

plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.[7]

The DMHC finished its first round of plan audits in early 2017. It issued reports to the carriers in the fall of 2017 and spring of 2018.[8] Preliminary findings released by the DMHC included continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

The Administration reviewed seventeen reports issued by DMHC. Of those seventeen reports, five noted potential MHPAEA violations that were addressed with the company. All of the concerning practices noted involved a carrier that delegated the utilization management of its behavioral health benefits to a third party. The issues included (1) using different definitions of medical necessity for M/S and MH/SUD services, (2) using varied medical necessity criteria for M/S services but only one set of criteria for MH/SUD services, (3) use of prior authorization and/or concurrent review for outpatient MH/SUD office visits but not for M/S office visits, (4) auto-authorization for M/S inpatient services but not for MH/SUD inpatient services, (5) no concurrent review for skilled nursing stays but requiring concurrent review for MH/SUD residential treatment stays, and (6) visit limits per authorization on MH/SUD office visits but not M/S visits.

The identification of these issues led some of the companies to correct the criteria, processes or utilization review requirements applied to behavioral health services. Other companies failed to make corrections and DMHC noted in the reports that review of the companies for corrective action addressing these issues would be conducted at the plan's next routine survey. None of the carriers were fined for violations of MHPAEA as a result of the surveys that were available for the Administration's review.

<u>Other States</u>

A number of other states are conducting comprehensive market conduct examinations to determine compliance with MHPAEA. Many of these examinations include the assistance of clinicians.

In 2018, Pennsylvania released two examination reports, one of Blue Cross of Northeastern Pennsylvania ("BCNP") d/b/a First Priority Health Insurance, Co., and one of Aetna.[9] *See* Attachment G. The BCNP report identified issues of parity coverage for behavioral

[7] Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

[8] The DMHC has been making the final reports available to the public on the DMHC's website.

[9] The Aetna examination included Aetna Health Insurance Company, Aetna Health, Inc., Health America, Inc., Health Assurance PA, Inc., and Aetna Life Insurance Company.

health services, as well as coverage issues for substance use disorder inpatient detox, nonhospital residential treatment and outpatient services. BCNP paid restitution and took corrective action. The Aetna report identified issues with coverage for autism spectrum disorder and substance use disorder. Pennsylvania concluded that Aetna used confusing policy language that implied there was no coverage for certain substance use disorder services. Aetna also applied incorrect copays, coinsurance and visit limits and had violations for prior authorization requirements and step therapy. Pennsylvania ordered restitution, corrective action and payment of a fine.

In August 2018, Rhode Island released its examination report of Blue Cross Blue Shield of Rhode Island ("BCBS"). *See* Attachment H. With the assistance of clinicians, Rhode Island assessed BCBS's behavioral health benefits for compliance with a variety of Rhode Island laws and regulations as well as the federal MHPAEA. The targeted examination focused on non-quantitative treatment limitations and utilization review policies, procedures and their implementation. The examination found that BCBS was using clinically inappropriate utilization review criteria for behavioral health service, which was also applied inappropriately. The examination also found that BCBS's utilization review was applied more stringently to behavioral health services and coverage exclusions applied to behavioral health services that were found to be in violation of MHPAEA. Rhode Island instructed BCBS to revise its behavioral health utilization review criteria, establish revised policies and procedures for utilization review of behavioral health services, and revise and narrow the scope of behavioral health services subject to prior authorization.

The Massachusetts Office of the Attorney General brought legal action against Aetna claiming violations of state law by maintaining inaccurate and deceptive provider directories and inadequacy provider networks. *See* Attachment I. Additionally, the AG alleged that Aetna violated state law by unfairly denying or impeding member coverage for substance use disorder treatments. In December 2018, Aetna entered into a settlement whereby it agreed to a number of terms, including covering specific medically necessary substance use disorder services and not requiring members to obtain preauthorization for specific substance use disorder services.

The Administration will submit the final results of the investigations into UnitedHealthcare entities upon their conclusion.

If you have any further questions, do not hesitate to contact me.

Sincerely,

Al Redmer, Jr.
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee and Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

ATTACHMENT 2

Appointment Wait Time for Non-Urgent MH/SUD Services 2018-2019 Comparison and Member Enrollment

Carrier	2018 Report[1]	2019 Report	Enrollment Individual Market[2] (7.31.19)	Enrollment Small Group Market[2] (7.31.19)
Aetna Health Ins.	82% (in 14 days)	89%	NA	166
Aetna Life Ins. Co.	82% (in 14 days)	89%	NA	629
CareFirst	95%	57.5%	11,493 (combined with GHMS)	22,158 (combined with GHMS)
CareFirst BlueChoice	95%	57.5%	108,301	168,248
CareFirst GHMS	95%	57.5%	11,493 (combined with CareFirst)	22,158 (combined with CareFirst)
Cigna Life and Health Ins. Co.	Missing data	76%	NA	NA
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA	NA
Golden Rule Ins. Co.	72%	96%	NA	NA
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	70,686	10,344
Kaiser Permanente Ins. Co.	Missing data	28%	NA	NA
MAMSI Life and Health Ins. Co.	72%	96%	NA	21,092
Optimum Choice Inc.	72%	96%	NA	17,205
United Healthcare Ins. Co. Choice Plus	72%	96%	NA	23,895[3]
United Healthcare Ins. Co. (CORE)	NA	96%	NA	
United Healthcare of the Mid-Atlantic Inc. (CORE)	72%	96%	NA	5,079[4]
United Healthcare of the Mid-Atlantic Inc. (Choice)	72%	96%	NA	

1. Reports are available at https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx and the Legal Action Center submitted an analysis of compliance to the MIA in September 2018. See Letter from Ellen Weber, Legal Action Center, to Robert Morrow, Assoc. Comm. Life & Health Maryland Insurance Administration, Sept. 18, 2018 (on file with the Legal Action Center).
2. Hogan Administration Announces Second Consecutive Decrease in Health Insurance Premiums, Sept. 19, 2019, available at https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2019236.
3. The enrollment data does not distinguish between United Healthcare Ins. Co's CORE and Choice plans.
4. The enrollment data does not distinguish between United Healthcare of the Mid-Atlantic CORE and Choice plans.

ATTACHMENT 3

Legal Action Center (2.10.20)
Carrier Compliance Reporting Requirements

	Maryland Bill	U.S. D.O.L.[i]	Delaware[ii]	Illinois[iii]	Colorado[iv]	New Jersey[v]	Connecticut[vi]	D.C.[vii]
Frequency	Annual	Annual	Once and subsequent for significant changes	Annual	Annual	Annual	Annual	Annual
List benefits and classifications	Sec. (C)(2)(I)	Step 1 at p. 14	18 Del. Admin. Code § 1410 App. A, A-1					
List all excluded benefits, reason	Sec. (C)(2)(II)							
Process for developing or selecting medical necessity criteria			§ 3343(g)(1); § 3571U(1)	215 ILCS § 5/ 370c.1(k)(4)	C.R.S.A. § 10-16-147(2)(b)(I)	N.J. Rev. Stat. § 26:2S-10.8(c)(1)	C.G.S.A. P.A. 19-159 § 1(b)(1)	D.C. Code § 31-3175.03(a)(2)
Identify all NQTLs	Sec. (C)(2)(III)	Step 1 at p. 13	§ 3343(g)(2); § 3571U(2) App. A-3; DDI Guidance Step 1[viii]	215 ILCS § 5/ 370c.1(k)(5)	C.R.S.A. § 10-16-147(2)(c)	N.J. Rev. Stat. § 26:2S-10.8 (c)(2)	C.G.S.A. P.A. 19-159 § 1(b)(2)	D.C. Code § 31-3175.03(a)(3)
Identify factors considered in designing NQTLs	Sec. (C)(2)(IV)	Step 2 at p. 14; Compliance tips at pp. 14 and 15 for subparts	§ 3343(g)(3)(a); § 3571U(3)(a) App. A-3; DDI Guidance Step 2,3, 4[ix]	215 ILCS § 5/ 370c.1(k)(6)(A)	C.R.S.A. § 10-16-147 (2)(d)(II)(A)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(a)	C.G.S.A. P.A. 19-159 § 1(b)(3)(A)	D.C. Code § 31-3175.03 (a)(4)(A)
Identify sources used to define/ establish NQTLs	Sec. (C)(2)(V)	Step 3 at p. 15; Compliance tip at 15 for subparts.	§ 3343(g)(3)(b); § 3571U(3)(b) App. A-3; DDI Guidance Step 2, 3, 4	215 ILCS § 5/ 370c.1(k)(6)(B)	C.R.S.A. § 10-16-147 (2)(d)(II)(B)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(b)	C.G.S.A. P.A. 19-159 § 1(b)(3)(B)	D.C. Code § 31-3175.03 (a)(4)(B)
Comparative Analysis of parity "as written"	Sec. (C)(2)(VI)	Step 4 at p. 16; Compliance tips at p. 16; p. 20 for audit.	§ 3343(g)(3)(c), (e); § 3571U(3)(c), (e) App. A-3; DDI Guidance Step 4[x]	215 ILCS § 5/ 370c.1(k)(6)(C), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(C), (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(c), (e)	C.G.S.A. P.A. 19-159 § 1(b)(3)(C), (E)	D.C. Code § 31-3175.03 (a)(4)(C), (E)
Comparative Analysis of parity "in operation"	Sec. (C)(2)(VII)	Step 4 at 16; Compliance tips at pp. 16 and 17; p. 20 for audit.	§ 3343(g)(3)(d), (e); § 3571U(3)(d), (e) App. A-3; DDI Guidance Step 5[xi]	215 ILCS § 5/ 370c.1(k)(6)(D), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(D), (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(d), (e)	C.G.S.A. P.A. 19-159 § 1(b)(3)(D), (E)	D.C. Code § 31-3175.03 (a)(4)(D), (E)
Process to comply with disclosure	Sec. (C)(2)(VIII)	Section G			C.R.S.A. § 10-16-113(3)(c)[xii]			

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[i] U.S. DOL, Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (2018), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.

[ii] DE Code § 3343; 3571U; 18 Del. Admin. Code § 1410 and App. 1; DDI Guidance Concerning Providing the Information Required on the NQTL Portion of the Data Collection Tool for Mental Health Parity Analysis, https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf; SB 230 (2018), https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocumentEngrossment?engrossmentId=13202&docTypeId=6. (Overlap: Aetna, BC/BS [Highmark], and United)
[iii] 215 ILCS § 5/370c.1; SB 1707 (2018), http://www.ilga.gov/legislation/publicacts/100/PDF/100-1024.pdf. **(Overlap: BC/BS and Cigna).**

[iv] Colo. Rev. Stat. Ann. § 10-16-147; HB 19-1269 (2019), http://leg.colorado.gov/sites/default/files/2019a_1269_signed.pdf. (Overlap: Aetna, BC/BS, Kaiser, and United)
[v] N.J. Rev. Stat. § 26:2S-10.8; AB 2031 (2019), https://legiscan.com/NJ/text/A2031/2018. **(Overlap: BC/BS [Horizon]).**

[vi] Conn. Gen. Stat. Ann. Pub. Act 19-159 (2019), https://www.cga.ct.gov/2019/ACT/pa/pdf/2019PA-00159-R00HB-07125-PA.pdf. **(Overlap: Aetna, BC/BS [Anthem], Cigna, and United)**.

[vii] D.C. Code § 31-3175.03; B22-0597 (2019), http://lims.dccouncil.us/Download/39262/B22-0597-SignedAct.pdf. **(Overlap: Aetna, CareFirst, Kaiser, and United).**

[viii] The Delaware Dept. of Insurance Guidance states that "each managed care organization and *its vendors (if applicable)* should refer to this document for full context regarding completing each step in the NQTL spreadsheet." (emphasis added). (p. 1). In addition, DDI's Step 4 comparative analysis of "written standards" identifies a review of "delegation contracts." (p. 3). The DDI's requirements are consistent with the HB 455/SB 334 provisions, VI(2) and VII(2), to identify measures that the carrier use to ensure that its **delegated entity** uses comparable design and application standards.

[ix] The Delaware Dept. of Insurance Guidance, Step 4, identifies, as part of the comparative analysis of the NQTLs as written, "the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved…." (p. 3). The DDI requirement is consistent with the HB 455/SB 334 provision, IV(1), regard title and qualification of employees making NQTL decisions.

[x] The Delaware Dept. of Insurance Guidance, Step 4, identifies a non-exhaustive list of internal reviews and analyses to support the plan's "as written" comparative analysis. See p. 3-4. The DDI requirement is consistent with the HB 455/SB334 provision, VI(1), requiring identification of the plan's analyses, audits or methods.

[xi] The Delaware Dept. of Insurance Guidance, Step 5, identifies a non-exhaustive list of audits to support the plan's "in operation" comparative analysis. Among the audits listed are: frequency of and reasons for reviews for the extension of initial authorization decision; audit results that demonstrate the frequency of reviews for MH/SUD and med/surg benefits were of equivalent stringency; audit/review of denial and appeal rates (both medical and administrative); analysis of out-of-network utilization; analysis of provider in-network participation. (pp. 4-5). The DDI requirements are consistent with the HB 455/SB334 provisions related to denial rates, (VII)(3), and data reporting requirements, Sec. D.

[xii] The statute mandates how plans comply with disclosure requirements, rather than asking plans to describe how they comply.

ATTACHMENT 4

Legal Action Center (2.10.20)
Carrier Data Collection Requirements

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
Frequency	Annual	Annual	Annual	Annual	Annual	Annual	Once, and subsequent for significant changes	Annual
MH/SUD Service Utilization	Total number and percentage of members who received MH/SUD benefits by level of care	Total number and percentage of members who received MH/SUD services by level of care	Total number of times patients/ providers requested MH, SUD, and Med/Surg services and the amount of services requested (number of visits, inpatient days)	Total number and percentage of members who received MH/SUD benefits by level of care		Number of beneficiaries treated for opioid use disorder		
Utilization Management Requests and Requirements	Number and percentage of utilization review requests and plan decisions related to prior authorization and concurrent review by parity classification	Number of utilization review requests for MH, SUD, and Med/Surg		Average length of stay for inpatient treatment; average number of sessions for outpatient treatment	Rates of utilization review and outcome for MH, SUD, and Med/Surg by parity classification; number of prior or concurrent authorization requests	Frequency with which plans required prior authorization	Audit to demonstrate that the frequency of all types of utilization review are comparable; frequency and reasons for review of extension on initial decisions	Data on parity compliance for adverse decisions regarding claims for MH and SUD services including total number of adverse decisions for such claims

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
Denials and Appeals	Number and percentage of denials and appeals of adverse and coverage decisions by parity classification	Number and rate of utilization requests denied and reason; number and rate of internal appeals and their outcomes; number and rate of external appeals and their outcomes	Number of service and outcomes; number of internal appeals and their outcomes; number of external appeals and their outcomes	Number and percentage of members denied prior and concurrent authorization; number of appeals by members and providers	Number of denials for MH, SUD, and Med/Surg by parity classification; rates of appeals and outcomes	The rates and reasons for denial of claims by parity classification	Audit/review of denial and appeal rates (medical and admin.) by service type or benefit category	
Network Utilization	Number and percentage of claims paid for in-network and out-of-network services by level of care	Number of providers (primary care, specialists, hospitals, and pharmacies) located in each county and the percentage that were board certified; procedures used to credential providers; provider-to-patient ratio	An explanation of any differences in the standards for granting authorization for out-of-network services; rates of provider disenrollment and reasons for disenrollment		Percentage of claims paid for in-network and out-of-network services; number and type of providers who are in-network; percentage of providers who remained in-network; any other data to evaluate network adequacy	List of in-network providers that prescribe opioid use disorder medications and type of medication; description of effort to ensure in-network capacity meets needs of insurer’s beneficiaries	Analysis of out-of-network and emergency utilization; Wait times for appointments, volume of claims filed, and types of services provided by in-network providers; market analysis of factors to establish provider reimbursement rates: supply	

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
							and need for provider type or specialty; analysis of provider in-network participation rate	
Claim Reimbursement	Claim expenses per member per month for MH, SUD, and Med/Surg; other data to evaluate reimbursement practices	Claims expenses per member per month for MH, SUD, and Med/Surg, by level of care; and a written statement of the types of financial arrangements with providers			Comparison of cost-sharing requirements and benefit limitations; any other data to evaluate reimbursement practices between MH/SUD and Med/Surg for in-network and out-of-network providers		Analysis of health plan's paid claims; internal review of published information identifying increasing costs	
Misc.		Discharge rates, average lengths of hospital stays, and percentage of patients who remained engaged in treatment after ED visits for MH/SUD or initiating treatment		Discharge rates from inpatient MH and SUD treatment, readmission rates; level of patient satisfaction with quality of MH and SUD care and treatment provided		Certification of comprehensive review of administrative practices for compliance with parity		

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
				under the insurance plan				

[i] CONN. GEN. STAT. §§ 38a-478c, 38a-478l; Conn. Dept. of Insurance, "Consumer Report Card On Health Insurance Carriers in Connecticut" (Oct. 2019), available at https://portal.ct.gov/-/media/CID/1_Reports/2019-ConsumerReportCard.pdf?la=en. **(Overlap: Aetna, BC/BS [Anthem], Cigna, and United).**

[ii] M.G.L. ch. 26, § 8K; Div. of Insurance Bulletin 2013-06, available at https://www.mass.gov/files/documents/2017/11/22/Bulletin%202013-06%20%28Mental%20Health%20Parity%29.pdf. **(Overlap: BC/BS and United).**

[iii] 18 V.S.A. § 414a; Regulation 2000-3-H, available at https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-regulation-health-h-2000-03-mental-health-substance-abuse.pdf. **(Overlap: BC/BS).**

[iv] N.Y. Ins. Law § 343 (2019), available at https://www.nysenate.gov/legislation/laws/ISC/343. (Overlap: Aetna, BCBS [Empire], and United)

[v] D.C. Code §§ 31-3175.03, 7-3202. **(Overlap: Aetna, CareFirst, Kaiser, and United).**

[vi] 18 DE Admin. Code § 1410 (2019), available at https://regulations.delaware.gov/register/june2019/final/22%20DE%20Reg%201025%2006-01-19.pdf; DE Div. of Insurance, Regulation 1410 – Appendix A and Guidance Concerning Providing the Information Required on the NQTL Portion of the Data Collection Tool for Mental Health Parity Analysis (2019), available at https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf. **(Overlap: Aetna, BC/BS [Highmark], and United).**

[vii] COLO. REV. STAT. § 10-16.147(2)(A). **(Overlap: Aetna, BC/BS [Anthem], Kaiser, and United)**

MRHA_FAV_SB 334
Uploaded by: Wilson, Lara
Position: FAV

Statement of Maryland Rural Health Association
To the Finance Committee
February 19, 2020
Senate Bill 334: Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria

POSITION: SUPPORT

Senators Augustine and Hester, Chair Kelley, Vice Chair Feldman, and members of the Finance Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 334: Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria.

This legislation would requires certain carriers, on or before March 1 each year, to submit a report to the Maryland Insurance Commissioner to demonstrate the carrier's compliance with the federal Mental Health Parity and Addiction Equity Act; requiring a carrier, on or before March 1 each year, to submit a report to the Commissioner on certain data for certain benefits by certain classification; establishing the Parity Enforcement and Education Fund to provide funds to support and conduct outreach to inform certain consumers of certain rights; etc.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population. Of Maryland's 24 jurisdictions, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state.

Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure." (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b)

The 2018 Maryland Rural Health Plan (www.MDRuralHealthPlan.org), an extensive assessment of Maryland's rural health needs, identified behavioral health problems as a prevalent concern in many rural counties. MRHA believes this legislation will help strengthen behavioral health care provision to one of Maryland's most vulnerable populations.

Lara Wilson, Executive Director, larawilson@mdruralhealth.org, 410-693-6988

JohnshopkinsCoble_FWA_SB334
Uploaded by: Coble, Annie
Position: FWA

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB 334

Supports with Amendments

TO: The Honorable Delores Kelley, Chair
Senate Finance Committee

FROM: Annie Coble
Policy Analyst, State Affairs

DATE: February 19, 2020

Johns Hopkins **supports with amendments Senate Bill 334 Health Insurance-Coverage for Mental Health Benefits and Substance Use Disorder Benefits- Treatment Criteria**. Senate Bill 334 requires health insurance carriers, including student health plans, to share a disclosure statement when a patient receives a notification from their carrier of an adverse decision regarding behavioral health services.

However, in 2016, the General Assembly passed HB 1247 which exempts self-funded student health plans from much of the Insurance Article. Johns Hopkins student health plans are covered by HB 1247 and therefore, exempt from state parity requirements. The plans are, however, subject to 15-10A and 15-10D, the appeal and grievance procedures, which contain the required disclosure. Thus, the disclosure statement as written in SB 334 would not apply to a patient covered under the Johns Hopkins Student Health Plan and they would receive inaccurate information if SB 334 is not amended.

Johns Hopkins University and Medicine is dedicated to creating parity. And Johns Hopkins student health plans are compliant with the federal parity laws and cover a variety of behavioral health services. The disclosure statement in SB 334 is a useful tool to educate Marylanders on their rights, and Johns Hopkins supports the intent of SB 334. We recommend a small amendment so that the language is accurate for all plans.

To address the concerns and ensure the accuracy of the disclosure statement, the language below is recommended:

> "Federal and state parity laws, TO THE EXTENT APPLICABLE TO YOUR PLAN, give you the right to receive mental health and substance use disorder benefits at the same level as physical health benefits. If you think your plan is not covering mental health or substance use disorder benefits at the same level, you may file a complaint with the Maryland Insurance Administration and the Health Advocacy Unit."

For these reasons, Johns Hopkins urges a **favorable with amendments report for Senate Bill 334.**

Recommended Amendment Direction

On page 16, in line 26, following "laws" insert "TO THE EXTENT APPLICABLE TO YOUR PLAN".

On page 18, in line 10, following "laws" insert "TO THE EXTENT APPLICABLE TO YOUR PLAN".

On page 20, in line 22, following "laws" insert "TO THE EXTENT APPLICABLE TO YOUR PLAN".

On page 21, in line 13, following "laws" insert "TO THE EXTENT APPLICABLE TO YOUR PLAN".

cc: Members, Senate Financial Committee
Senator Malcolm Augustine
Senator Katie Fry Hester

Kaiser Permanente_INFO_SB 334

Uploaded by: Taylor, Allison
Position: INFO

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 19, 2020

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 334 – Information

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente is providing the following information for SB 334, Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 755,000 members. In Maryland, we deliver care to over 430,000 members.

KP and other stakeholders have been working collaboratively toward a solution for SB 334. That work is ongoing, and we appreciate the leadership of the bill sponsors and the opportunity to engage on this important issue.

Thank you for the opportunity to comment. Please feel free to contact Wayne Wilson at Wayne.D.Wilson@kp.org or (301) 816-5991 with questions.

Sincerely,

Wayne D. Wilson
Vice President, Government Programs and External Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.